REPORT OF THE PHYSICIAN PAYMENT REVIEW COMMISSION; AND FISCAL YEAR 1988 BUDGET ISSUES RELATED TO PHYSICIAN PAYMENT UNDER THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

MARCH 3, 1987

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CONTENTS

Page

Press release of Tuesday, February 17, 1987, announcing the hearing 2

WITNESSES

Physician Payment Review Commission, Philip R. Lee, M.D., Chairman, and Paul B. Ginsburg, Executive Director 6

American Academy of Family Physicians, Robert Graham, M.D 81
American College of Physicians, C.S. Lewis, Jr., M.D., and John R. Ball, M.D... 55
American College of Surgeons, Paul A. Ebert, M.D 76
Ball, John R., M.D., American College of Physicians 55
Ebert, Paul A., M.D., American College of Surgeons 76
Graham, Robert, M.D., American Academy of Family Physicians 81
Hsiao, William C., Ph.D., Harvard University, School of Public Health 25
Lewis, C.S., Jr., M.D., American College of Physicians, and University of Oklahoma, Tulsa Medical Center 55
Roe, Benson B., M.D., University of California, San Francisco Medical Center.. 45
Stason, William B., M.D., West Roxbury Veterans' Administration Medical Center 39

SUBMISSIONS FOR THE RECORD

Albers, John E., M.D., Society of Thoracic Surgeons, letter 128
American Academy of Orthopaedic Surgeons, Reginald Cooper, M.D., statement 97
American Association of Retired Persons, statement 99
American College of Gastroenterology, Edwin M. Cohn, M.D., statement 102
American Medical Association, statement and attachment 104
American Society of Internal Medicine, statement 112
Association of Professional Sleep Societies, Martin A. Cohn, M.D., statement ... 124
Cohn, Edwin M., M.D., American College of Gastroenterology, statement 102
Cohn, Martin A., M.D., Mt. Sinai Medical Center, on behalf of Association of Professional Sleep Societies, statement 124
Cooper, Reginald, M.D., American Academy of Orthopaedic Surgeons, statement 97
McConnel, Charles E., Ph.D., Southwest Long Term Care Gerontology Center, statement and attachment 129
Mt. Sinai Medical Center, Sleep Disorders Center, Martin A. Cohn, M.D., statement 124
National Association of Medical Directors of Respiratory Care, statement 126
Society of Thoracic Surgeons, John E. Albers, M.D., letter 128
Southwest Long Term Care Gerontology Center, Charles E. McConnel, Ph.D., statement and attachment 129

REPORT OF THE PHYSICIAN PAYMENT REVIEW COMMISSION; AND FISCAL YEAR 1988 BUDGET ISSUES RELATED TO PHYSICIAN PAYMENT UNDER THE MEDICARE PROGRAM

TUESDAY, MARCH 3, 1987

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:23 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, FEBRUARY 17, 1987

PRESS RELEASE #3
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE REPORT TO CONGRESS OF THE MEDICARE PHYSICIAN PAYMENT REVIEW COMMISSION AND ON FISCAL YEAR 1988 BUDGET ISSUES RELATED TO PHYSICIAN PAYMENT UNDER THE MEDICARE PROGRAM

The Honorable Fortney H. (Pete) Stark (D. Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee on Health will hold a hearing on physician payment under Medicare Part B.

The hearing will begin at 10:00 a.m., on Tuesday, March 3, 1987, in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark said, "Medicare payments for physicians' services continue to increase rapidly. Yet, the elderly still incur substantial out-of-pocket costs. This is unacceptable for Congress, for the elderly, and for taxpayers. Reform is long overdue."

The March 3 hearing will focus on overall reform of Medicare physician payment and on Fiscal Year 1988 budget issues pertaining to physician reimbursement. Philip R. Lee, M.D., Chairman of the Physician Payment Review Commission, will present the Commission's first annual report to Congress.

BACKGROUND

Medicare Part B provides insurance coverage of physicians' services for the elderly and disabled. Medicare payments are made on a fee-for-service basis. The amount of payment allowed is determined on the basis of the "customary, prevailing, and reasonable charge" (CPR) methodology. During the 22 years since enactment in 1965, the CPR payment system has remained fundamentally unchanged. In the interval, however, it has become increasingly apparent that CPR is seriously flawed.

Despite a number of cost-control measures, outlays for physicians' services have continued to grow rapidly. Even during the 1984 - 1986 fee freeze, total payments increased at a rate of about 10 percent per year, primarily because of increases in volume and intensity of services. Total payments are expected to reach $22 billion this year.

Another problem involves extra charges on unassigned claims. Physicians (and other Part B providers) have the option of accepting or refusing assignment. If assignment is accepted, the physician submits a claim to Medicare directly and bills the patient for the standard 20% coinsurance payment. No extra charges are permitted. However, if assignment is refused, the physician bills the patient and may charge more than the Medicare approved fee.

Extra charges on unassigned claims are a heavy financial burden for the elderly. During 1987, extra charges on Part B services will total more than $3 billion, and 700,000 elderly will incur extra charges in excess of $1000.

Thus, even though costs to taxpayers have increased rapidly, the elderly still receive only partial financial protection from high charges for physician services. Because of these, and other problems, a consensus has developed in support of fundamental reform of physician payment.

To assist in the reform process, Congress has set in motion two major efforts -- the Physician Payment Review Commission and the development of a cost-based relative value scale. The March 3 hearing will focus on both of these efforts.

The first witness will be Philip R. Lee, M.D., Chairman of the Physician Payment Review Commission who will present to the Subcommittee the Commission's first annual report to Congress. Dr. Lee's presentation to the Subcommittee will be the first public discussion of the Commission's report. The report is expected to contain recommendations concerning the use of a fee schedule as an alternative to CPR. The report is also expected to contain recommendations concerning fees in rural areas.

The second witness will be William Hsiao, Ph.D., of the Harvard School of Public Health. Dr. Hsiao is under contract with the Health Care Financing Administration to develop a cost-based relative value scale that could be used as the basis for setting physician payments under Medicare.

Other witnesses will discuss options the Subcommittee may consider to meet Fiscal Year 1988 budget reconciliation targets. Subsequent hearings will be held to consider a variety of other physician payment issues, including the participating physician program and proposals to pay radiologists, anesthesiologists, and pathologists on a per-admission basis using Diagnosis Related Groups (DRGs).

Oral testimony will be heard from _invited witnesses only_. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, March 31, 1987, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS

*****

Chairman **Stark**. We are now, for the audience, going to hear from the Physician Payment Review Commission. If the audience would like to move seats—and the staff will be handing out new materials—the Chair will read his opening statement, and you will offend no one if you wander around while I'm reading this deathless prose.

We did enact, in 1965, a part B Medicare to ensure that our elderly could afford to pay for physician services. Today, 22 years later, our goals remain the same, and the elderly must be assured access to high-quality care they can afford.

At the same time, the program must be affordable to the taxpayers.

Measured by these standards, Medicare part B is in serious trouble and in need of repair. Since 1965 our health care system has undergone revolutionary change, but Medicare's payment system for physician services has remained fundamentally unchanged. The system is unfair to the elderly, unfair to taxpayers, and, indeed, unfair to many physicians.

Reform of this system will be difficult and will take time. To assist in this process, Congress established the Physician Payment Review Commission and mandated the development of a relative value scale. We will learn more about these efforts in the first half of today's hearing. In the second half of the hearing we will consider short-term options to meet our 1988 budget targets. It's important that our short-term efforts be consistent with our long-term goals. We should try and remember there are services, such as office visits, in areas of the country where payments are too low, and thus we should try to avoid across-the-board cuts or freezes that affect all physicians equally. Those, I might add, are politically sometimes a lot easier. But instead we should focus our attention on services where the Medicare payment is higher than the amount which assures access to high-quality care. Options of this type include the use of a relative value scale to identify overpriced procedures, geographic caps that cut payments in areas where fees exceed the national average even after adjusting for differences of cost. While an across-the-board reduction is the easy way out politically, it's more difficult to single out a small group because you need to justify the choice.

It's my hope that today's witnesses will provide advice and support for a fair and equitable plan. We need to reaffirm our commitment to the elderly in assuring their access to affordable care of the highest quality. Payment reform must not increase costs to the elderly, and to this end I intend to work vigorously to strengthen the participating physician program and limits on extra and excessive charges.

We are privileged to have as our first witness, Dr. Philip Lee, Chairman of the Physician Payment Review Commission. He will discuss the Commission's first report to the Congress, which we think is an outstanding contribution and lays a sound foundation for future reform.

Before Dr. Lee proceeds, I'd like to recognize Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

Mr. Chairman, when Dr. Bowen appeared before our committee last week, our colleague from New Hampshire asked him to describe the administration strategy on the issue of Medicare physician payment performance

The Secretary outlined the administration's budget proposals affecting physicians, and his chief of staff described the Department's private health plan initiatives.

Their answers were disappointing. I understand the problem they have of supporting the budget and trying to suggest that they have a plan, but it was not an adequate response to this very important issue.

We have the elements of a strategy. They have been put in place by this Congress in the last year or two, in particular by the provisions of the Omnibus Budget Reconciliation Act, the second reconciliation bill, which was signed by the President last fall. Maybe I am reading more into what we did than is there, but let me outline what I believe the elements of this strategy are, because I think it's appropriate to this hearing and the very important role which Dr. Ginsburg will play in flushing this out.

First of all, we ended the physician freeze, and in so doing indicated that the freeze which we had had was a matter of budget policy, not health policy. I think that was a very important motion.

Chairman STARK. Excuse me, would the gentleman yield? Just for the record, would you make a statement as to who led the charge for ending that freeze? On our side of the aisle.

Mr. GRADISON. I always like to give credit where credit is due. I see the gentleman from Texas has arrived.

Second, in terms of short-term reform the legislation specifies a process for implementing inherent reasonableness. Indeed we applied the principle specifically to fees for cataract procedures in our legislation.

The third thing that that act did was include incentives to enhance participation. In particular, we increased the differential between participating and non-participating physicians.

The fourth thing we did was limit the levels by which nonparticipating physicians can increase their unassigned claims over the next 4 years.

Fifth, and probably in the long run the most important, we instructed the Secretary to use a relative value scale for physician services, which in essence directs him by July 1 of this year to recommend to Congress the mechanism for implementing restructuring of the "customary, prevailing, and reasonable" charge scheme.

Today we are going to receive the first report of the Physician Payment Review Commission, which will assist us in implementing this strategy. If they think the strategy is wrong, I know they will tell us, and I value their recommendations and am very pleased by what I have heard so far and seen so far about their work.

These refinements in the traditional Medicare reimbursement system probably will take place at the same time that capitation plans which we are also encouraging continue to grow. But I don't think we can wait for all beneficiaries to join such plans before we reform physician payment. I think the fees are parallel tracks down which we will be moving over a long period of years.

Mr. Chairman, in conclusion, I want to praise Dr. Lee and the members of his commission. They have done an outstanding job in a remarkably short period of time in producing an initial report which not only gives us guidance but I think also encourages this member to believe that the elements which we have already set out as a strategy may just be doable.

Thank you, Mr. Chairman.

Chairman STARK. Thank you, Mr. Gradison.

It is with a good deal of pleasure that I welcome Dr. Phil Lee, who is Chairman of the Physician Payment Review Commission, and his colleague Dr. Paul Ginsburg, who is the Executive Director.

Doctor, your testimony will appear in the record in its entirety. You are encouraged to read it, add to it, summarize it, or otherwise enlighten the committee in any manner you feel comfortable.

Proceed.

STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN OF THE PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED BY PAUL B. GINSBURG, PH.D., EXECUTIVE DIRECTOR

Dr. LEE. Thank you very much, Mr. Chairman.

I think that the Commission would associate itself with your comments and also with Mr. Gradison's comments with respect to the actions taken by Congress. The directions that have been set are consistent, we believe, with the ultimate policy decisions that need to be reached with respect to the reform of payments to physicians under Medicare.

I would like to submit the testimony for the record, and a copy of the first annual report, "Medicare Physician Payment: An Agenda for Reform," I wish also to review briefly four points in the testimony: the Commission's role and mandate; the criticisms of the current Medicare method of paying physicians, which led to the creation of the Commission; the goals that have guided the Commission; the major recommendations and next steps.

The Commission has four roles. First it, provides independent expert advice to Congress and the Secetary of Health and Human Services. Second, it provides an opportunity for various groups—beneficiaries, physicians, and other interested parties—to express their views in depth and to have them considered in deliberations on policies for paying physicians, and to do that in open hearings. Third, the Commission conducts objective analyses to provide a basis for deciding upon options that can be considered by Congress. Finally, it performs what we call "design work," which is necessary to implement major changes. As an example of such work, the Commission has suggested in the report, the use of concensus panels to resolve issues involved in the inherent reasonableness of physicians' fees. The Commission believes it can provide advice to Congress more promptly than would be possible through the mechanisms that have been established.

In its mandate the Commission is required to submit a report by March 1 each year. The legislation directs the Commission's attention to methods of adjusting levels of reasonable charges, setting rates, and making payments for physicians' services. The mandate also requires the Commission to consider several more specific issues, such as the differences in payments because of a physician's geographic location or specialty, the use of assistance in surgery, and physicians' acceptance of assignment of Medicare patients.

The criticisms of the current payment methods are well known to the members of this committee. The "customary, prevailing, and reasonable" method is based on a physician's actual charges, the customary charges in the previous year, and the prevailing charges of other physicians in the area.

The Commission believes, and I think the evidence strongly supports this, that the current method encourages increases in physician charges and increases in the volume of services provided. It is creating patterns that embody inappropriate incentives for the use of medical services. It is affecting physicians' decisions with respect to specialty and location of practice: there are, for example, disincentives for providing primary care and, we believe, for establishing practices in underserved rural areas.

Finally, the current system of paying physicians is very complex administratively. Beneficiaries do not understand it and physicians do not understand it; that may also be true of a lot of other people.

The Commission has set for itself a number of goals. First of all, it would ensure that beneficiaries would have access to care. The Commission also wants to maintain or improve the quality of care and maintain the financial protection of the beneficiaries. Equity among physicians should ensure that similar payments are made for similar services among similarly qualified physicians. The growth of Federal outlays for the supplementary medical insurance program must be slowed. The system must be made understandable. The Commission also wants to make changes in methods of payment that are orderly and coherent, and we believe the steps Congress has taken are consistent with that goal, as well as a number of the others. Finally, the Commission believes that the physician payment system should accommodate the various ways health services are organized—solo practice, group practice, health maintenance organizations, and other forms.

In the recommendations of the work plan, the Commission looked at four alternatives. One was to refine the current system. A second was to examine fee schedules. A third was to create a system of all-inclusive fees for a defined package of services, so-called global fees in the minds of some. And a fourth was to increase the use of capitation. We have a very particular view about what should be included in the definition of capitation and what should not be.

With respect to recommendations, the Commission first endorsed the concept of a fee schedule for Medicare. Under such an arrangement, the pattern of payments for services would differ from the current system by type of procedure, practice setting, geographic location, and perhaps by specialty. To adopt a fee schedule requires major decisions on design. For example, how should the relative values be determined? How are payments to take into consideration differences in practice settings and geographic locations? How should fee schedules be updated over time? And is a different policy concerning assignment needed?

Those are very difficult questions, and they will be the kinds that we will be addressing.

The Commission was also concerned about geographic variations in payment. We made a specific recommendation to provide a special payment incentive, or increment, for primary care services provided in underserved areas, either rural or urban. The additional payment would not affect coinsurance amounts. It could be financed by a small reduction in the update factor for the Medicare Economic Index. As a rule of thumb, we were informed, for each one-tenth of 1 percentage point reduction in the update factor, $10 million could be provided for those special payments.

The Commission endorsed the idea of inherent reasonableness, although we felt that the system adopted to make decision on inherent reasonableness was very complex. We do not recommend a change at the present time, but we will work with consensus panels addressing inherent reasonableness of high-cost procedures or services. We will try to provide timely information to Congress that may supplement the information provided through the current system. We probably will not be able to provide information in time for decision that must be made for fiscal year 1988, but we will certainly do the best we can. We would want to work closely with you on that.

With respect to assignment and the participating physician program, we felt that the provisions included in the Omnibus Budget Reconciliation Act of 1986 to increase assignment through improvements in the information provided to beneficiaries and changes in incentives for physicians were important. And in view of the number of policy changes that have been made, they need to be carefully monitored and evaluated, but we would not now recommend further changes.

Mr. Pickle. Would or would not?

Dr. Lee. We would not recommend additional changes at the present time, Congressman Pickle.

The Commission also plans to examine a number of methods of rebasing the Medicare Economic Index. We tested some and found that certain of our assumptions were not correct. We need to study the methods in more depth prior to making specific recommendations.

The Commission considers improvements in program administration to be a key element in the reform of Medicare physician payment. Our recommendations cover funding, flexibility for carriers, standards for carriers—and that would include getting rid of carriers who are inefficient or, ineffective—and research into effective carrier activities.

Another issue we considered in some detail was coding, and here the American College of Surgeons was very helpful to us. The Commission has established a subcommittee chaired by Dr. Oliver Beahrs of the Mayo Clinic, who is chairman of the Board of Regents of the American College of Surgeons, to investigate coding issues and the kinds of unbundling that increase expenditures. We hope the subcommittee will be able to make recommendations that will be truly useful.

The Commission has also recommended that Medicare limits on payments for assistants at surgery be supplemented by additional definitions and guidelines. An assistant at surgery should be defined as an individual who has the necessary qualifications to participate in the particular type of operation and who actively assists the surgeon in performing the surgical procedure. We have some more things to say about that in the report.

We want to commend the Health Care Financing Administration for the progress that it has made in improving data systems, and also Congress for the requirements it has mandated in this area. Data are very important for monitoring the consequences of various policy choices that have been made.

The Commission has had a limited time in which to conduct its activities, recruit staff, and hold its meetings, so that there are some subjects that were not addressed: quality of care, variations in payment by physician speciality, the requirement of second opinions before surgery is undertaken, payment of such hospital-based physicians as radiologists, anesthesiologists, and pathologists on a per-case basis, and payment for physicians' services and other medical services through capitation arrangements. The Commission plans to take up these and other issues in the future.

The Commission's work will focus on refinements that address specific aspects of the current payment system, geographic variation in charges, inherent reasonableness, coding, and the development of fee schedules that could replace the current method of payment. In addition, it will begin to take up issues that it did not have time to address before submitting this report and new issues that arise in policy debates during the coming year.

We expect to make continued progress and come to you on March 1 next year with a second annual report that has a broader scope and additional depth. I will be going before your colleagues on the Senate Appropriations Committee today and those on the House Appropriations Committee next month to discuss the resources we need to accomplish our mission. We would, of course, ask for any assistance you would be willing to provide us in that regard. And Dr. Ginsburg and I will be pleased to answer any questions you may have about the Commission and its first report. I give great credit to Paul and to the staff for the quality of the report and for the work that has been accomplished to date.

Thank you very much.

[The prepared statement follows:]

Statement of the
Physician Payment Review Commission
on its First Annual Report

Medicare Physician Payment:
An Agenda for Reform

Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Philip R. Lee, M.D.
Chairman
March 3, 1987

Mr. Chairman, it is with a great sense of accomplishment that I come before this Committee with the first annual report of the Physician Payment Review Commission. This report represents the Commission's first step in meeting its Congressional mandate to advise on improvements in how physicians are paid for serving Medicare beneficiaries.

The Physician Payment Review Commission (PPRC) began work in November 1986 with the first meeting of its thirteen Commissioners. These Commissioners represent a broad range of experience and perspectives on physician payment. Many have appeared before this and other Committees to share their expertise on a wide variety of public policy concerns. The Commission has devoted two of its meetings to hearing the views of interested organizations, many of which also commented on drafts of the annual report.

In only four months with a small newly hired staff and the complications of several poorly timed snowstorms, the Commission has developed a set of recommendations that we believe will be helpful to you. We were able to prepare this report in such a short time only because we had the generous assistance of many individuals and organizations, both public and private, including several staff of the Congress.

This hearing comes at an important time for the future of the Medicare program. The program, particularly its physician services component, continues to be one of the largest and fastest growing parts of the federal budget. It consumes about 8 percent of that budget and almost 2 percent of the gross national product. Budgetary concerns necessarily are having an ever greater influence on Medicare policies, requiring a difficult balancing of budgetary constraints against the goals of financial protection and access to care for beneficiaries. The Commission recognizes your need for fiscally realistic advice but is also sensitive to your expectations that the needs of beneficiaries will weigh heavily in our recommendations.

This first report of the Physician Payment Review Commission offers a number of recommendations which I will summarize. I would be pleased to submit the entire report of the Commission for the record. My written statement is based largely on the report's Executive Summary which highlights:

- the Commission's roles and mandate;
- the criticisms of Medicare's current method of paying physicians, which led to the creation of the Commission;
- the goals that have guided the Commission's recommendations and the tradeoffs among goals that the Commission and the Congress must face; and
- the major recommendations of the Commission and its next steps.

COMMISSION ROLES AND MANDATE

The Commission has defined four broad roles for itself. First, it serves as a source of independent expert advice to the Congress and to the Secretary of Health and Human Services. Second, PPRC provides opportunities for beneficiaries, physicians, and other interested parties to have their views considered in policy deliberations on physician payment issues. Third, the Commission conducts objective analyses to provide a basis for policy decisions to alter Medicare's method of paying physicians. Fourth, it performs some of the design work necessary to implement major changes in physician payment.

The Congress called for PPRC to submit its recommendations by March 1 of each year. The legislation directs the Commission's attention to the methods of adjusting reasonable charge levels, setting rates, and making payment for physicians' services. The mandate also requires us to consider more specific issues including differences in payments based on specialty or geographic location, use of assistants at surgery, and acceptance of assignment by physicians.

CRITICISMS OF CURRENT PAYMENT METHOD

When Medicare was adopted in 1965, policymakers specified in broad terms how the program should pay physicians. Payment was to be based on reasonable charges. These were defined as a physician's actual charges, as long as those charges did not exceed the physician's customary charges in the previous year or the prevailing charges of other doctors in the locality. These guidelines provided the basis for CPR, the "customary, prevailing and reasonable" method of Medicare physician payment.

As you are well aware, the CPR payment methodology has come under increasing criticism because of the poor incentives it provides for cost-effective service delivery. In particular, it has been criticized for:

- encouraging increases in physicians' charges and service volume;
- creating patterns of allowed charges that embody inappropriate incentives for the use of medical services as well as for physicians' decisions on where to locate and what to specialize in; and
- being administratively complex and difficult for both physicians and beneficiaries to understand.

GOALS FOR PHYSICIAN PAYMENT POLICY

The Medicare program was designed to provide the elderly with financial protection from the costs of medical care and, in the process, to increase access to services of high quality. In assessing options for reform in physician payment, the Commission is guided by the following goals:

Access to Care. Reforms in the methods for paying for physicians' services must ensure that all beneficiaries have access to medical care. For those beneficiaries electing to continue to receive care through the fee-for-service system, free choice of physician must be maintained.

Quality of Care. Reforms should maintain or improve the quality of care provided to Medicare beneficiaries. Beneficiaries should receive high quality care provided through efficient medical practice.

Financial Protection for Beneficiaries. Changes in payment to physicians should maintain financial protection for beneficiaries. While some patient financial responsibility for the cost of care may be appropriate, levels of responsibility should not be so high that they prevent beneficiaries from gaining access to care or impose significant economic hardship. The Commission is particularly concerned with limiting the responsibility of beneficiaries for charges in excess of what Medicare allows. We are also concerned that the growing shift of care to outpatient settings, which brings many non-economic benefits to patients, should not subject beneficiaries to undue financial burdens because of the less generous coverage and payments provided for most out-of-hospital services.

Equity among Physicians. Reforms in the levels or methods of payment should increase equity among physicians, so that similar payments are made for similar services among similarly qualified physicians. Differences in payments for different services should broadly reflect relative costs, market conditions, and other appropriate factors.

Reduction in the Growth of SMI Outlays. Changes in physician payment should slow the growth in federal outlays for Supplementary Medical Insurance. The growing burden on taxpayers, who underwrite 75 percent of program costs through general revenues, and beneficiaries, who underwrite 25 percent of the cost through premiums, is becoming an increasingly serious problem. One way to reduce costs rather than merely shift them to others is to encourage increased efficiency in the practice of medicine. This can be achieved through more appropriate payment incentives to physicians, improved review of how services are used, expanded research, and better education of physicians and beneficiaries. In evaluating policy changes that reduce outlays in Part B of Medicare, the potential for offsetting increases in outlays for Part A of Medicare must be considered.

Understandability. Reforms should make the method of paying physicians easier for beneficiaries, physicians, and the general public to understand. Physicians should know what charges Medicare will allow, and beneficiaries should be informed by physicians what they are expected to pay. When feasible, this information should be provided before service is delivered.

Orderly Change. Changes in the method of payment should be orderly and coherent. Short-term change should be consistent with long-term policy goals. The feasibility of administering the specific changes must be taken into account, especially in setting schedules for their implementation. As major reforms are implemented, monitoring their effects should be given high priority because these effects are uncertain and midcourse corrections may be required.

Pluralism. Reforms in payment methods should accommodate the various ways health services are organized. Both fee-for-service methods and capitation should play a role in the delivery of medical care in the United States.

In its study of Medicare's methods of paying physicians, the Commission has come to three conclusions that will guide it in making specific recommendations. First, tradeoffs among the goals outlined above are inevitable. While certain goals can be achieved simultaneously--for example, more efficient medical practice may increase quality of care--conflicts among the goals may well arise. When tradeoffs must be made, access to care and financial protection for beneficiaries should not be sacrificed.

Second, current differences in charges for physician services provide distorted signals to physicians and cause serious inequities among physicians. These distortions and inequities may affect physicians' decisions concerning what services to provide, what specialty to train for, and where to locate a medical practice. Careful attempts to develop relative value scales that take into account factors in addition to existing patterns of charges may lead to relative payments that will provide more appropriate signals to physicians.

Third, since medical care is both an art and a science, physicians' decisions will continue to be pivotal in the delivery of effective care. One central challenge to policy is to find a way to incorporate society's concerns about limited resources into physicians' decisionmaking while maintaining the physician's freedom and responsibility to exercise clinical judgment on behalf of the patient.

RECOMMENDATIONS AND WORKPLAN

The Commission has considered four general alternatives for reforming the way physicians are paid under the Medicare program: refining the current payment system, making payments according to a fee schedule, creating a system of all-inclusive fees for defined packages of services, and increasing the use of capitation payments. In this initial report, the Commission focuses on the first two alternatives. The other alternatives, which present more problems and questions for near-term adoption, will be taken up in subsequent reports.

The Commission has charted a course to follow for the long term and has recommended immediate improvements in the current payment system that are consistent with long-term objectives. The first recommendation describes the Commission's plans to develop a fee schedule. Other PPRC recommendations apply primarily to the current payment system, but they also will be relevant to the adoption of a fee schedule.

A Fee Schedule

The Commission endorses the concept of a fee schedule for Medicare. Under such an arrangement, the pattern of payments for services would differ from that under the current system by type of procedure, practice setting, geographic location, and perhaps by specialty. Adoption of a fee schedule requires major decisions on design. For example, how should relative values be determined? How are payments to vary by practice setting and geographic location? How should the payments be updated over time? And, is a different policy concerning assignment needed? We plan to examine these and other issues during the next year.

The Commission does not consider its endorsement of a fee schedule for Medicare as precluding future recommendation of other methods for paying for physicians' services, either in addition to or in place of fee for service. We plan to study such alternative ways of paying for physicians' services as all-inclusive fees and capitation.

Geographic Variation

Because of the Commission's serious concerns that geographic variations in physician payment limit access to care for beneficiaries and create inequities among physicians, the Commission recommends a special payment increment for primary care services provided in designated underserved areas. It could be financed by a small reduction in the annual update factor for the Medicare Economic Index and would not affect beneficiary coinsurance amounts. The PPRC expects to consider more comprehensive approaches to geographic variation in payment.

Inherent Reasonableness

The Commission endorses the use of recently enacted provisions on "inherent reasonableness" to make interim changes in relative payments. When applied carefully through an open process that takes into account the views of interested parties, inherent reasonableness could repair distortions in relative payments that have arisen under current payment methods. Such changes may achieve short-term budget savings in ways that are more consistent with long-term policy directions than are across-the-board reductions in payment rates.

Application of inherent reasonableness will increase payments for some services and reduce them for others. The increases that do occur need not rule out a net decrease in Medicare outlays for physicians' services.

The Commission has concerns, however, that the procedural requirements of the legislation defining inherent reasonableness, in conjunction with limitations of data and research funds, will limit the extent to which the process authorized can be used to change payment patterns. To augment the limited data available, we plan to test a consensus process for developing recommendations for changes in payment.

This process will not be available in time to assist the Secretary of HHS or the Congress with decisions for the Fiscal Year 1988 budget cycle. Nevertheless, if asked for assistance with decisions on inherent reasonableness so that objectives for FY88 might be met, we will attempt to provide some guidance through more limited mechanisms. These include a review of the implications of various relative value scales that have been developed in the United States and abroad.

Assignment and the Participating Physician Program

The PPRC notes the potential of the numerous provisions in the Omnibus Budget Reconciliation Act of 1986 to increase assignment through improvements in the information provided to beneficiaries and changes in incentives for physicians. In view of the recent enactment and pending implementation of these policy changes, the Commission's recommendations focus on the need for careful monitoring and evaluation. In addition, we plan to devote continuing attention to additional ways to ease claims processing for participating physicians and to increase beneficiaries' familiarity with the participating physician program.

The Medicare Economic Index

Over more than a decade, the Medicare Economic Index (MEI) has limited rates of increase in allowable charges. Although the weights have been updated periodically, the index continues to be applied to 1973 prevailing charges. The Commission plans to examine a number of methods for rebasing the MEI. Rebasing is likely to have a substantial effect on relative payments, so before recommending a specific method, PPRC wants to ensure that changes are generally consistent with the types of fee schedules it contemplates and that those changes would not increase program expenditures.

Program Administration

The Commission considers improvement in program administration to be a key element in the reform of Medicare physician payment. Our recommendations cover four areas: funding, flexibility for carriers, standards for carriers, and research on effective carrier activities.

Adequate funding of Medicare administration is critical to protecting beneficiaries and containing benefit costs. Funding levels should reflect the complexity and scope of program requirements. The funding provided to carriers can go further if the carriers are given greater flexibility to allocate funds to their most productive uses.

At the same time, strong standards for carriers' processing of claims in areas such as prompt payment, accuracy, and service to beneficiaries and physicians should be a priority, and persistently poor performers should be replaced. With respect to prompt payment, I am particularly concerned to learn that the President's FY88 budget request forecasts an increase in the average time for processing claims from 15 days in FY86 to 20 days in FY87 and 26 days in FY88.

The effectiveness of various carrier activities has not been studied adequately. The Commission recommends that HCFA expand research to identify cost-effective utilization review and other benefit cost management techniques used by carriers, Peer Review Organizations, and private payers.

Coding

Lack of refinement and standardization in the coding of procedures has been a serious problem in administering physician payments and could be a limiting factor in implementing a fee schedule. The PPRC recommends that the definition of codes for medical and surgical services, including those representing services covered by global fees for surgery, be refined and standardized. The Commission will convene an expert panel to make recommendations for change.

Assistance at Surgery

Medicare typically pays for assistance at surgery by physicians and others. Serious doubts have been raised about how frequently physicians are needed as assistants and whether payment by Medicare is appropriate. The PPRC recommends that Medicare limits on payment for assistance at surgery be supplemented by additional definitions and guidelines. An assistant at surgery should be defined as an individual who has the necessary qualifications to participate in the particular type of operation and who actively assists the surgeon in performing the surgical procedure. Medicare also must specify practical guidelines for claims review by carriers. The PPRC plans to test the use of panels of surgeons and others to develop practical guidelines for carriers.

Data

Timely, relevant and accurate data are crucial to the consideration of reforms in Medicare physician payment methods as well as to program management, quality assessment, and utilization review. The Commission notes the recent progress in improving data systems by the Health Care Financing Administration and encourages continued efforts in this area, particularly those mandated by the Congress in recent legislation. The Commission will assist HCFA and other federal agencies in their planning of future improvements in Medicare data.

FUTURE STEPS

As a result of the limited time available to the Commission to prepare this first annual report, not all important topics in physician payment policy could be addressed. Those that have been deferred include specific steps to increase the quality of care, variation in payments by physician specialty, the use of surgical second opinions, per case payment of hospital-based physicians such as radiologists, anesthesiologists, and pathologists, and the payment for physician and other medical services through capitation arrangements. The Commission plans to take up these and other issues in the future.

The Commission's policy recommendations represent first steps in the process of reform. The workplan defines the effort required in the coming year to provide the basis for further recommendations for change. The Commission's work will focus on both refinements that address specific aspects of the current payment system--geographic variation in charges, inherent reasonableness, coding--and the development of a fee schedule that could replace the current method of payment. In addition, the Commission will begin to take up issues it did not have time to address prior to this report and new issues that arise in the policy debate during the coming year.

I appreciate this opportunity to present the Commission's report to you. We believe that it can help you navigate the very complex and troublesome course of balancing budgetary objectives with the social goals of the Medicare program. We hope that we may further assist you during the next few months as you go through this process.

In the coming year, we expect to make much progress and come to you with a second annual report that has broader scope and additional depth. Today and next month I will be going before your colleagues on the Appropriations Committees to discuss the resources we need to accomplish our mission. I will be pleased to answer any questions you may have about the Commission and this first report.

Chairman **Stark**. Doctor, thank you very much. Is somebody running the clock? Start it on me. And I'm sure the members will go around twice if need be, but I'd like to give everybody a chance to inquire of Dr. Lee.

I have two areas of concern that perhaps you can help me with. One, do you feel that the variation in fees across the country, whether or not they are justified—I can see justification based on office expense and rent and things that are relatively easy for us to determine, they are very empirical—but in what appears to be different styles or habits of practice. Do you think that your Commission is going to be able to make some empirical headway there in helping us find out why one procedure may cost twice as much in one city as another, or is that something that is just going to take a long time. Will the payment schedules that we may come up with eventually force some more uniformity in practice?

Dr. **Lee**. Based on the evidence we have seen, some of those differences are justified because of the higher cost of personnel and the higher cost of living in some areas. But a procedure can cost from three to six or seven times in one area what it costs in another. And the communities may not be that distant geographically. Those differences are not justified. We believe that the Commission and the staff can provide much more comprehensive analysis of those geographic differences and come up with some recommendations that will be practical and useful for Congress.

Chairman **Stark**. Politically, though, if you are going to cut somebody's fee in one neighborhood you are going to have the political pressure from that neighborhood saying how come this fee was cut. And if we have to say the reason we are cutting it is because you could buy it across the river or across the country for half, that will be difficult for us. And the more you can focus on that for us, the easier it will be.

Dr. **Lee**. Under the current system an internist in Beverly Hills can receive a payment for a given procedure that is significantly greater than the payment of an internist in Watts for the same procedure. Now those places are perhaps a mile apart. But to be able to consider such cases with confidence, we have to do more analysis. I think that that will be possible.

Mr. **Ginsburg**. When the staff looked into the state of research on the issue of geographic variation, we found that there wasn't much of it and what was there tended to be very old, with data of much poorer quality than have recently become available. So we are optimistic that by using some of the newer HCFA claims files—the so-called BMAD files—we can understand geographic variation much better.

Chairman **Stark**. Doctor, the other area that I am concerned about is what I refer to as noncash incentives, or inducements—and particularly, in the area of participation. First of all, at some point it would seem to me that a payment for the participating physician could be calculated, and you could add inducements, such as less bookkeeping, less hassle with whatever carriers, so that they'd all say that's swell, why don't I take a little less money and I'll get a little less hassle. Or perhaps the idea of guaranteeing a certain amount of work—we'll fill out your appointment book for you if you will take these extra patients and take them at a cut rate.

Are you looking into, in a sense—again getting back to that term—noncash ways in which we might buy the services at a savings?

Dr. LEE. The Commission has looked at, and will look at in more detail, program administration, especially prompt payment, which, oddly enough might be considered a noncash incentive. If a participating physician has rendered a service and payments are delayed 30 days or longer, that's a cash problem. So that some method of improving claims administration and prompt payment is a noncash incentive.

Chairman STARK. Unfortunately the OMB is a step ahead of you, they are going to score us down on that one.

Dr. LEE. Well, they go the other direction, but we are talking about incentives. Another incentive is to provide information to beneficiaries. We have done a very limited job of that up to now. Ways must also be found to reach individual beneficiaries so that they really become informed—and some of the earlier discussion on insurance for medical catastrophes illustrates how much misunderstanding there can be—before they have to make a choice at the point of acute illness. When you have to have an operation and you are in the emergency room, you are not going to ask somebody if they are a participating physician and if the answer is no, say I would rather have somebody else. Some actions by the Health Care Financing Administration have begun to resolve this problem, and perhaps significant progress can be made.

Other nonfinancial incentives or disincentives can be investigated. For example, in Massachusetts there are disincentives for physicians who do not accept assignment in Medicare. And that we certainly intend to look at.

If Medicare moves to a fee schedule, if the inequities that now exist are corrected and physicians are more satisfied, physician participation will, on average, increase. That, however, is more a monetary issue.

Finally, in the course of setting a fee schedule, there is negotiation, and if the fee schedules are established by negotiation, physicians should be more willing to accept assignment—participation implies that.

Chairman STARK. Thank you very much. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. Dr. Lee, I'd like to pick up initially on your final comment. It certainly had been my hope that we could defuse this very controversial issue by some form of negotiation, and that the notion of requiring assignment would be one of the issues on the table. Is that your understanding as well?

Dr. LEE. Yes. Several members of the Commission, including Dick Wright, who is from Caterpillar and who deals with the benefits and negotiates with physicians, like that approach. I like it too. But one of the problems is who negotiates for the physicians? Do you negotiate at the national level? If so, then who represents the physicians? Can you do it at the State level, as they do in Canada, where they have provincial negotiations? Because Medicare represents only a certain portion of physician income, can you negotiate only a certain portion of their fees? In Canada the whole bundle is negotiated. So there are some barriers to negotiation, although we are going to see if some modifications of the negotiation process could be used in setting a fee schedule.

Mr. **Gradison.** I don't pretend to know a whole lot about the relative value scales or the relative value groupings. I have examined the way it's done in anethesiology, and, if I understand it correctly, subject to periodic reviews, and taking into account the changes in procedures and practice and risk and skills, in the end it comes down to a negotiation on a price per hour. Is that correct? Once the scale is set, what would you negotiate other than how much you are going to pay per hour, in terms of skill and risk?

Dr. **Lee.** I think I would agree with that. Paul, is that the essence of it?

Mr. **Ginsburg.** It's not as simple as that because of the variations in complexity of different hours of service.

Mr. **Gradison.** But isn't that built into the scale?

Mr. **Ginsburg.** Sure, that's why it's not a mechanical thing of just studying the hours; it does have to be negotiated.

Mr. **Gradison.** I don't mean to make this sound easy—I know how difficult it is—but once the factors are built in which determine the extra weights related particularly to risk and skill, and if you use, as I think anesthesiology does, 15-minute increments, don't you eventually come back to whether you are going to pay $20 or $25 an hour, which later may turn out to be a higher payment, if weighted more heavily?

Dr. **Lee.** Or $500 an hour.

Mr. **Gradison.** Well, it may turn out to be that, if you have a times-20 factor built in—I understand that.

Okay, if we move to a relative value scale system, how do we deal with the nagging issue of volume? To what extent is the increase in physician payments that we are now experiencing under part B, an increase which is well above the increase one would expect from the increased number of elderly and all these screens and scales we have—to what extent is this a volume increase and how would you deal with this issue if you were to conclude that some portion of increased physician payments is simply a matter of physicians' saying if they can't get higher payment in price they'll get it in volume?

Dr. **Lee.** Volume is a very key issue in physician payment, and one the Commision has just begun to look at. The present system is such that there are very substantial incentives for services that do not relate to the costs of producing those services. Dr. Bill Hsaio of Harvard is going to talk with you later about the cost-based approach.

If we move toward a cost-based approach in an RVS, which we would hope to do, there is neither an incentive to produce a service, let's say, colonoscopy or gastroscopy, that is financially lucrative in relation to costs nor an incentive to underprovide a service like a long office visit to explain to a patient carefully about the need for a particular drug or combination of drugs, or to listen to a patient with a complex problem.

The incentives would be in a sense neutral in relation to what it costs to provide the services. So that would be a factor.

Mr. **Gradison**. But how would you deal with—and I'm not sure if this is common at all—with a situation where the physician said, Mrs. Smith, you are making good progress, but I'd rather you come in twice a month instead of monthly for me to check your blood pressure?

Dr. **Lee**. If inappropriate services are being provided, there has to be more effective monitoring of physician services. Under Medicare, under the hospital reviews, we do have data to conduct utilization reviews, although the data have not so far permitted reviews of the practices of inidividual physicians. As those data systems are improved it will be possible to look at outliers, to look at people whose behavior is inappropriate in relation to norms of practice.

The studies that Dr. Wennberg and others have done show enormous variations in practices that are not easy to explain on the basis of either payment or other factors. Funding for that research is going to be very substantially increased, so we should have a lot more help in understanding those variations.

Mr. **Gradison**. Thank you, Doctor; thank you, Mr. Chairman.

Chairman **Stark**. Mr. Moody.

Mr. **Moody**. I'll defer the questions and yield.

Chairman **Stark**. Mr. Levin.

Mr. **Levin**. Let me refer to pages 3 and 4 where you talk about the criticisms and the goals. I'm kind of playing catchup here, so let me go back—I'm new to the subcommittee. Doctor, if you would, how do you prioritize the problems and the goals? I don't mean in a very strict sense, but in orders of magnitude, what are the main problems with the present system?

Dr. **Lee**. In terms of the Commission's intention and goals, beneficiary protections come first, more than cost containment, more than equity among physicians. Ensuring access to care, maintaining quality, and maintaining financial protection of the beneficiaries—those are the most important goals and should be included in any proposals for physician payment reform under Medicare.

Mr. **Levin**. Do you think there's broad agreement on those priorities within the field? I'm not sure within Congress it would be in terms of the cost to the budget, but do you think there is a fairly broad consensus behind beneficiary protections first with cost containment and equity among physicians secondary?

Dr. **Lee**. If you asked OMB, the budget would come first. If you asked some physicians, particularly some of those who practice in rural areas, they might say that equity among physicians would be the most important goal, but partly because that would ensure greater access to care in those areas. We had some very eloquent testimony in that regard. Among the beneficiaries of Medicare, among the elderly and the groups that represent the elderly, beneficiary access, quality of care, and financial protection are unquestionably most important. I cannot speak for Congress.

Mr. **Levin**. Well, you are kind of, as you say here, an objective observer. Why do you prioritize the areas the way you do?

Dr. **Lee**. I hope we used the word "independent."

Mr. **Levin**. Not objective.

Dr. **Lee**. Not necessarily objective. All the Commissioners come with, various prejudices, interests, backgrounds—and that, of course, means the Commission is not entirely an objective body. But it is at least an independent body.

Why did we reach the conclusions we did? Because of what we heard and because of the discussions that we had, which were quite lengthy, on what the priorities should be. In the beginning some of us thought the first priority would be budgetary; that was not at all the outcome. Some others thought physician equity; that was not where the Commissioners came out either.

Mr. LEVIN. Describe it; we didn't live through the meetings.

Dr. LEE. Take Ollie Beahrs, for example. He is a very distinguished surgeon from the Mayo Clinic, the primary physician overseeing the President's recent surgery. He made a very direct statement at the first hearing of the Commission that it wasn't his intention to represent the College of Surgeons, even though he had been recommended by them and was chairman of their board of regents. He thought it was the Commission's responsibility first of all to look after the interests of the beneficiaries. It was that sort of viewpoint, I think, that swayed other Commissioners.

Mr. LEVIN. Just one last question on that. Is it because you felt that was your responsibility or is it because, as you looked at the facts and the materials presented to you, you thought that was the area of the greatest problem?

Dr. LEE. I would say we thought the interests of beneficiaries were our greatest responsibility—and there were substantial problems because of the increasing burden that has been placed on beneficiaries by policy developments, particularly since 1981.

Mr. LEVIN. So quality, access, and the financial impact.

Dr. LEE. Right. And if one looks at the effects of DRG's—I know this committee has done that—one of the unintended effects of the shorter hospital stay has been burdens in the posthospital period. The consequences of that for the beneficiary were perhaps unintended. That is why we want to be sure we are not making recommendations that are going to have unintended consequences for beneficiaries—shifting costs to beneficiaries, for example, by increased balanced billing—if we make some recommendations with respect to fee schedules.

Mr. LEVIN. Thank you very much.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman. Doctor, like my colleague from Michigan, I'm playing catchup, too, as a new member of the committee.

In your comment on page 3, "creating patterns of allowed charges that embody inappropriate incentives for the use of medical services as well as for physicians' decisions on where to locate and what to specialize in * * *"—it would be helpful to me if you could comment a little more about that. The "inappropriate incentives," is that for the patient, the recipient of care, or for the physician, or both?

Dr. LEE. The incentives in the payment system are largely for the physician, and there are substantial incentives in the current payment system, for example, to perform procedures rather than not perform procedures. If an office visit is augmented with a procedure, a physician can earn much more. If a patient comes in with a stomach ache and wonders whether he has an ulcer, a physican has an incentive to perform a gastroscopy rather than taking a detailed history, which may take a lot of time. The payment for a gastroscopy is about at least four times as much per hour as the payment for an office visit. If laboratory procedures are added to an office visit, whether or not they are entirely necessary, that augments the physician's income. These incentives are actually disincentives for what some have called "cognitive services." We think of surgery and medicine as cognitive, so I don't like to use the term, but for the nonprocedural services there tend to be some disincentives for simply listening to a patient. Again, a physician may take care of a patient who has had a heart attack in an intensive care unit, then may subsequently care for that patient over a 3-month period of recovery. The patient may then require several diagnostic or additional diagnostic procedures, and then maybe surgery. An internist who provides such services, perhaps a hundred hours, would receive compensation that perhaps would barely equal the fee of the surgeon who performed the procedure.

So that there are those kinds of flaws that skew the system. And some of the studies that Dr. Hsaio will be presenting to you later show that the costs of performing those services many times have no relation to the charges that physicians make and the payments that are made.

Mr. CHANDLER. If I have time for one more, Mr. Chairman, do you feel that on the patient's side of it that people are choosing to see a doctor even though at some time in the past when there was not payment for having done so, they might have? Are the people going to the doctor for problems like colds because they can be paid for, whereas if it weren't they would choose not to go?

Dr. LEE. Because Medicare removed both the costs and the fear of the costs, particularly the costs of hospitalization, we have seen a significant increase in utilization by the elderly. Data indicate that this has resulted in extraordinary improvements in the health of the elderly and increased life expectancy. We have thus had benefits strictly from the increased access to medical care that we really did not anticipate at the time Medicare was enacted, not to mention other benefits like a reduction in smoking.

Some people probably are going for an office visit for relatively minor problems when they would not have gone in the past. But that is far more balanced by those who are going for necessary surgery, going for necessary medical care—treatment of hypertension, for example—so I think the benefits far outweigh the additional costs that may have come from unnecessary utilization for relatively minor problems.

Mr. CHANDLER. Thank you, Mr. Chairman.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman. Dr. Lee, I'm impressed with your report and I find it very interesting. I think it will be helpful to us. I would like to have a list of the members of the Commission.

Dr. LEE. Yes, sir.

Mr. PICKLE. I'd just like to see who's on the Commission and the area they come from and that type of thing.

Dr. LEE. One of your distinguished colleagues, Jim Bob Brame, a general practitioner from Eldorado, Texas, is a member of the

Commission. The Commission members are listed in the report, and we would be glad also to make that immediately available to you.

Mr. PICKLE. I'd like to see that. How often have you met?

Dr. LEE. The Commission has met every month since November.

Mr. PICKLE. Now, you are making this report to us by March, in accordance with either the mandate or your agreement.

Dr. LEE. We interpreted the law to say that we had to submit a report by March 1.

Mr. PICKLE. How often would you report to us?

Dr. LEE. We will make a report on March 1 each year.

Mr. PICKLE. You mean we won't get a report from you until next March?

Dr. LEE. No, sir. We will work with this committee and with your staff, and if there are particular issues that you want us to examine—for example, issues concerning inherent reasonableness—we would examine those issues and would report periodically to this committee on our findings.

Mr. PICKLE. I noticed in your report that you make some general expressions but few specific recommendations, because you are just getting into this.

Dr. LEE. Correct.

Mr. PICKLE. And I can understand that. You do say you endorse the concept of a fee schedule. I take that to mean that you are trying to find a better answer other than the one we presently have, is that correct?

Dr. LEE. That is correct. We have not reached an agreement about what method we should use to develop a relative value scale—should it be cost-based, should it be charge-based, should it be negotiated, and so forth.

Mr. PICKLE. Well, as you proceed with our meetings, during the year, will you be making recommendations to us whether you do endorse the fee schedule and what kind of a fee schedule you would endorse?

Dr. LEE. Yes. If we reach that conclusion before March 1 of next year, we would certainly come back to this committee with those recommendations.

Mr. PICKLE. Now, as you and your Commission, as directed by law, and based on your appointment—you are trying to make these recommendations—as I understand it we also have HCFA proceeding with a study. They have Dr. Hsaio.

Dr. LEE. Dr. Hsaio is here and he will be testifying before you later.

Mr. PICKLE. I'm interested in knowing how you work with that group. HCFA is doing the same thing you're doing. Are you working with them? I assume you are. But how are you working, and who will make the determination which way we will go?

Dr. LEE. You will make that determination, or Congress will make that determination. One of the reasons the Commission was established was to provide Congress with an independent judgment on these matters so it would not have to be dependent entirely on the executive branch for recommendations.

Mr. PICKLE. I think that's good.

Dr. LEE. The Health Care Financing Administration is mandated by Congress to give a report by July 1, 1989; it was originally, I think, July 1 of this year. We will certainly be working with them, but independently of them. Dr. Ginsburg, of course, with his staff, will be continuously addressing these issues as the Commission reports periodically and meets periodically. We will be hearing from Dr. Hsiao, for example, at our April hearing of the Commission. We will also be hearing from the administration at the April hearing.

Mr. PICKLE. I take it that as you proceed with additional meetings, and HCFA or Dr. Hsaio looking at the same issues, that we should not expect an immediate recommendation about fees, but it may well be into the latter part of this year or next. Do you have any time schedule when you think you would make a recommendation about fee schedules?

Dr. LEE. We should certainly be able to make some recommendations by March 1 of next year. It is unlikely that we could make recommendations that would be solidly based before that time, and final recommendations might not come until the following year.

Mr. PICKLE. In your report you do not make specific recommendations on assignment, or you do not make recommendations on rebasing; you defer these things.

Dr. LEE. Correct.

Mr. PICKLE. But you do say that in the meantime you could make specific recommendations about second opinions——

Dr. LEE. Yes.

Mr. PICKLE. And in other areas you would be making recommendations as you go along. I'm simply asking these questions trying to find out how we fit in and who is working with or in competition with——

Dr. LEE. We think that we can do some good analytic studies on rebasing and that we can come back with recommendations. And if there is an area that has a priority, inherent reasonableness is one of those; coding is another. For investigations of both we intend to use consensus panels so that we can make early recommendations that may be of practical value. We do not want to wait until next year.

Mr. PICKLE. Well, I want to conclude by saying that I am impressed with your report; I think you are working at it; I hope you continue these regular meetings, give us the benefit of your recommendations as you go along.

Dr. LEE. Thank you, sir.

Chairman STARK. Mr. Coyne.

Mr. COYNE. I have no questions, Mr. Chairman.

Chairman STARK. Are there any other Members who have additional comments or questions for Dr. Lee or Dr. Ginsburg?

Dr. LEE. Mr. Chairman, I would just add in closing——

Chairman STARK. Please.

Dr. LEE [continuing]. That if any of the members have additional questions they would want to submit to the Commission in writing, we would be more than happy to answer them.

Chairman STARK. Again, I'm excited by the work you're doing; I think the subcommittee is. And I look forward to assisting you as you approach the Appropriations Committees so that you have the resources to continue this good work.

Thank you very much for being with us.

Dr. LEE. Thank you very much. Just on a personal note, if I can be of any assistance to the committee in dealing with the issues of long-term care and catastrophic illness, I would certainly be glad to do that, not in my role as Chairman of the Physician Payment Review Commission, but because of my role at UC, San Francisco.

Chairman STARK. Well, thank you. As you know, this subcommittee tries often to work in informal study sessions, because many of the areas that we deal in are very technical, and we will take you up on that offer.

Dr. LEE. Thank you.

Chairman STARK. I assume you are offering Dr. Ginsburg's services, too, whether he likes it or not.

Dr. LEE. Absolutely.

Chairman STARK. So we will call on you, and appreciate your being with us this morning.

Dr. LEE. Thank you.

Chairman STARK. Our next witness is Dr. William Hsiao, who is Professor of Health Economics at Harvard School of Public Health.

Doctor, your prepared testimony will appear in the record in its entirety, and you may summarize it or expand on it in any manner you care to.

Please proceed.

STATEMENT OF WILLIAM C. HSIAO, PH.D., PROFESSOR OF ECONOMICS AND HEALTH POLICY, HARVARD UNIVERSITY, SCHOOL OF PUBLIC HEALTH

Mr. HSIAO. Mr. Chairman, I am pleased to be here to report to you briefly on the Harvard study on relative values.

The U.S. Congress had mandated HCFA to conduct a relative value study. As a result, HCFA solicited proposals from researchers throughout the United States. And we were fortunate that our proposal was judged to be the best designed and scientifically most rigorous by a panel of outside technical experts, and also by the Government officials. And I am here this morning as the principal investigator of this study.

What I would like to do briefly is cover two major points in my oral presentation. The first is the reasons why we believe that physician payments cannot be based on their charges; and, second, to explain bases and the methods of the Harvard study which is trying to develop a relative value scale based on resource costs.

Medicare and private insurance have based their payments to physicians on what they charge. This practice assumes the physician service market is reasonably competitive. The charges therefore represent the physicians' costs. We know, however, that is not true.

A competitive market requires the consumer capable of making informed choices and also to pay for the services when they are rendered, so the patients are sensitive to the price they have to pay. Thus the consumers will do some competitive price shopping.

We know one of the distortions in this marketplace is the presence of the insurance. We know throughout our economy, regardless of what type of insurance, when insurance is present, the providers is less concerned to raise their prices. Let me illustrate.

In the automobile repair industry, if you are unfortunate to have been in a car crash and the car's body is damaged, you take the car in, and one of the first questions they ask you is do you have insurance? If the answer is yes, the repair estimate is $2,800. If the answer is no, the estimate is probably half of that amount. This is how insurance distorts the price structure.

Moreover, we also often turn to doctors for care when we are in acute pain or a life-threatening situations. Under those circumstances, patients do not have the time nor the presence of mind to shop for the best doctor. Allow me again to draw an analogy here.

Let us say a house is on fire, and a private enterprise fire brigade to shop for a competitive price? The private fire brigade comes and logically would demand a high price to put out a fire. Would the house owner bargain hard and call another fire brigade to shop for a competitive price?

Therefore, to use charges as the basis paying physicians under those circumstances seems to be unreasonable. And the civilized nations have long prevented this kind of economic arrangements by providing fire and police protections as a public service. But, in the medical field, we continue to leave the charges to the discretion of physicians and rely on their professional ethics to guide the doctors. This works well sometimes and sometimes fails miserably.

Because of these market imperfections, there is little price competition in the physician service market, and the charges are seriously distorted. Dr. Philip Lee has testified earlier and illustrated that often the service for one procedure may be four times or five times higher than the comparable procedure that requires about the same effort. Based on the relative amount of work involved, we know that there are many services that are overpriced while others are relatively underpriced.

Now, let me turn to the Harvard study. This study is to develop an alternative base to establish payment for physician services. We purposely tried to move away from a charge base. The concept for the Harvard study is to measure the cost. We developed methods to measure the relative input cost for performing physician services. Costs often can be measured objectively. It is generally accepted as a sound base for reimbursement in other fields, including the hospitals.

We identified the input cost for physician services to include the average time required to perform the procedure or service, the intensity of time, the professional training required, and the practice costs. Let me elaborate a little bit.

Time I think is self-evident. This can also be measured objectively. Intensity is less self-evident. What do we mean by intensity? Intensity in our study includes the technical skill required to perform the service, the stress the physicians feel doing that service, the judgment and mental effort required and the probability of iatrogenic harm to the patient due to of this procedure of service.

It will be unfair to equate an hour of doing a well baby checkup with 1 hour performing open heart surgery. So the intensity of that effort is a very critical element for us to measure.

Also we take into account variations in the practice costs between geographical regions and between specialties. As you know so well, medical malpractice premiums alone can vary sometimes tenfold between specialties.

The Harvard study began about 15 months ago, and is scheduled to be completed by July 1, 1988. And we are committed to submit a final report to the Secretary of HHS by that date, and I am happy to report to you that we are on schedule.

Finally, Mr. Chairman, I would like to share with you that the Harvard study has the cooperation and support of the wide physician community. The American Medical Association and more than 30 medical and surgical societies are working closely with us in collaboration, as well as giving us technical advice.

We have appointed a panel of more than 100 physicians, and they represent every significant medical specialty. These panel members are advising us on the technical and medical aspects of our investigation.

Now, in closing, let me say I am confident this study funded by the wisdom of Congress, you mandated it, through HCFA, will develop an alternative base to pay physicians. The results from the study can be used as a fundamental block to reform the method of paying doctors. We will provide objective standards to establish payment rates, and the resource based relative value scales can be used to correct the inequities and distorted fees that exist in the current marketplace.

Finally, I want to express my personal gratitude to have this opportunity to come before you and present the progress of this study. And I would be happy to answer any questions.

[The prepared statement follows:]

Statement before House Committee on Ways and Means

by
William C. Hsiao

Professor of Economics and Health Policy
Harvard University

March 3,1987

In the United States, the competitive market is relied upon to determine the prices of commodities and services. Physician payments are no exception. We pay physicians according to what they charge.

The physician service market, however, does not meet the basic conditions for a competitive market. The wide spread of insurance coverage reduces the consumer's sensitivity to the fees physicians charge. Physicians do not compete on prices. Consumer sovereignty is also largely absent because patients do not have adequate medical knowledge to choose medical services. Instead, we rely on doctors to make decisions for us. Finally, many medical services involve life-threatening conditions; patients would hardly consider what physicians will charge under these circumstances. These special characteristics of physician services places doctors in an autonomous and dominating role in the marketplace. Physicians, therefore, enjoy freedom to set their charges, decide the type of service to be provided, and influence the quantitly of services patients receive. Even the recent price competition between insurance plans and HMOs has not produced direct price competition among physicians.

The payment rates for physician services under Medicare and Medicaid, meanwhile, have been largely based on what the doctors charge. These practices simply institutionalize the distorted prices produced by the imperfect market-place. They have a profound impact on health care cost inflation, the quantity of services rendered, the availability of primary care doctors, the wide disparities in fees charged for the same service, and the accessibility of physician services in rural communities.

Higher health care cost and reduced quality.

Charges and payment rates are currently tilted in favor of surgical and technical procedures. Our research studies have found that when compared on the basis of time and effort required, surgical procedures are compensated two to three times more than medical services (see Table 1). This price structure provides incentive for doctors to perform the more costly procedures, which causes higher inflation. At the same time, many unnecessary surgical and technical services are rendered that have questionable value to the patient, sometimes resulting in complications and death.

The magnitude of this impact can be inferred by comparing the frequency of surgery under the fee-for-service system and under HMOs. Studies have found the differences range from 10 to 25 percent, particularly for discretionary procedures such as tonsilectomy and hysterectomy.

Maldistribution of specialists.

The distorted price structure provides incentives for medical school graduates to select higher-compensated specialties, while leaving less compensated specialties with a shortage of doctors. Studies conducted by the Federal Government showed that we have a surplus of surgical specialists, while we have a shortage of primary care physicians.

Wide disparities in fees charged.

Fees vary widely for performing the same medical service. In my studies I found charges for routine office visits vary by 200 percent in the same community. The charges for a surgical operation such as appendectomy vary from $525 to $900 in the same community.

There are greater variations in fees charged for the same service across regions. At least three-fold differences are observed. Los Angeles and New York City are the highest, while doctors practicing in rural areas charge the lowest. The differences in practice cost and cost of living across regions can only explain a small portion of the variations in the charges. Meanwhile, physicians' workload can explain more. Doctors with fewer patients charge more. This phenomenon indicates the marketplace does not work very well.

Shortage of physicians in rural areas while there is an oversupply in urban areas.

Because of the imperfections in the physician marketplace, we have observed an unusual phenomenon that contradicts the standard economic law. In a competitive marketplace, the greater number of sellers, the lower the price of the product. The opposite is true in the physician service market: the greater the number of physicians in a service area, the higher the price charged. This phenomenon is consistent with the theory that physicians occupy an autonomous and dominant postion which allows them to set their prices without adequate constraint by competition, there are no incentives then for physicians to redistribute themselves from over-supplied areas to under-supplied areas. This practice contributes to the shortage of doctors in rural communities and inner cities.

Recommendations.

The following recommendations are made to achieve several public goals: Contain health care cost inflation, improve quality of services, and improve the distribution of physicians.

A. Alter the basis of payment rates: Payment rates should not be based on the charges made by physicians because the market is imperfect. Any payment system based on physician charges would institutionalize the unfair fee structure of the current system. Payment should be based on objective criteria produced through scientific method, such as the resource-based relative value scale that is currently being developed. A resource-based relative value scale is needed regardless of what payment system the Congress adopts. We need a rational base which serves as a basic building block to compensate physicians equitably and fairly. This is true regardless whether we compensate physcians on a fee-for-service basis, on a physician DRG system on rates established through negotiations between payor and physicians, or by capitation rates. Each method would require information as to the resource input costs for performing physician services.

Adoption of the resource-based relative value scales would moderate health care cost inflation and provide the incentives for physicians to choose the appropriate modality of treatment in caring for patients.

The current study on resource-based relative value scales, funded by the Health Care Financing Administration, covers 12 major specialties. The development of resource-based relative value scales is a complicated task that requires medical expertise, economic analysis, statistical information and cost analysis. This study is scheduled to be completed by July 1, 1988.

B. Establish equitable payment rates across geographical areas: The current price variations between geographical areas may be a major contributing cause to the shortage of doctors in rural communities and inner cities. A study should be done to identify the economic differences among geopgrphic areas that would justify different payment rates. The study should take into account the differences in practice costs, cost of living, and supply of physicians. The Government can then use this information to establish fair and equitable payment rates that will help to reduce the shortage of physicians in some communities.

Congress should consider legislation that would offer bonus payments for physicians to locate in under-served areas. The Canadian experience shows that economic incentive can have a significant influence on new physicians as to where they locate their practices.

C. Control "billing code creep": Billing codes for physician services have increased three-fold in recent years. Fine distinctions are made in codes for physician services which encourage the fragmentation of services as well as encouraging physicians to label their services in such a way that would justify higher payment. Studies have found that billing code creep has been a significant contributing factor in the recent health care cost inflation. The current codes could be reduced significantly for payment purposes, while providing equitable compensation to physicians.

D. Set target budgets for physician services by geographical area: Physicians can set their prices as well as influence the quantity of services demanded by patients. Experience under the Medicaid program has shown that price regulation is not very effective in controlling physician expenditures because the volume of services is increased to compensate for any control in payment rates. Therefore, a target budget needs to be set in order to monitor the effectiveness of payment regulation.

E. Mandate demonstration projects on experimental methods of compensating physicians: The physician DRG payment system has merit because it reduced fragmentated billing and also a physician becomes the gatekeeper for the patient in a given episode of illness. However, there are serious technical and operational problems in the physician DRG payment method. Nonetheless, this approach has sufficient merit that the Government should conduct demonstration projects to learn how feasible it is to reimburse physicians on DRG basis.

Table 1

Comparison of Relative Values Calculated from 1983 Medicare Charges and Resource Inputs

General Surgery

	Charge-Based		Resource-Based	
	Charges	Ratio	Value	Ratio
Initial Complete Office Visit	$ 52	1.0	0.4	1.0
Initial Intermediate Hospital Visit	100	1.9	-	-
Appendectomy	550	10.6	1.0	2.5
Total Abdominal Hysterectomy	1,100	21.2	2.1	5.3

Cardiovascular Surgery

	Charges	Ratio	Value	Ratio
Initial Complete Office Visit	$ 80	1.0	0.5	1.0
Initial Intermediate Hospital Visit	110	1.4	-	-
Insertion of Pacemaker	1,060	13.3	1.6	3.2
Coronary Artery Bypass	3,000	37.5	7.5	15.0

Ophthalmology

	Charges	Ratio	Value	Ratio
Initial Comprehensive Eye Exam	50	1.0	0.5	1.0
Simple Extraction of Lens	1,100	22.0	1.5	3.0

From the Massachusetts Relative Value
Scale Study conducted by Harvard
University, School of Public Health.

Chairman **Stark**. Thank you, Dr. Hsiao.

Could you describe a little bit more about the procedure or the process that you are using? For example, do you involve the various physician groups or physicians in your study to the various subspecialty groups or specialty groups and feel comfortable with it, or do you find that they are antagonized or are antagonistic in dealing with it? Give me a little idea of what kind of feedback you get.

Mr. **Hsiao**. Sure. Let me divide my answer into two parts.

First, we know at the start that a study such as this requires tremendous amounts of expertise in clinical medicine. Therefore, on the project, we have several physicians on the staff of the project. They include surgeons, internal medicine, psychiatry. We also have anesthesiologist and radiologist who offer their time voluntarily.

So, there are clinicians who are closely involved with the project. Outside the staff, we worked closely with the American Medical Association, and through the American Medical Association all the major specialty societies were contacted and we sought their help and cooperation with this study. I am happy to report, and gratified to say that we received the support basically from almost all of the specialty societies, as well as the American Medical Association.

The project appointed a technical consultant panel that I mentioned in my earlier testimony. The panel consists of roughly 100 physicians covering about more than 25 specialties. We brought these physicians to Boston for a 2-day meeting. I will confess there when the meeting began there was, at best, a great deal of wait and see attitudes. There was also some strong antagonism. For example questions are asked such as, why are you disturbing our tranquil world? What do you know about physicians' work? How can you measure the cost of what we are doing?

And we went through some very organized presentations about our methodology, our conceptual framework. Through the process, we worked with the physicians, we are delighted that most of the physicians suspended their prior judgments, and they began to see there is a certain validity and reasonableness and objectivity in our approach; that is, trying to measure objectively the input costs of physician services.

At the end of the two-day meeting, we certainly noticed a big change in physicians' attitudes. Subsequently, we received letters and phone calls from our technical consultant panel members voluntarily offering a great deal of help. The medical specialty societies and the AMA have also cooperated closely with the study and being of great assistance. We were invited throughout the Nation to give presentations to medical groups because they think the study is a very interesting, as well as worthwhile activity.

Let me just mention that Dr. Benson Roe is here. He is a witness later on. Dr. Roe is a member of the technical consultant members and he will keep me honest and you can also get an independent view from Dr. Roe.

Chairman **Stark**. Thank you. And one other comment, if you would care to, and that is, this year, driven by budget targets, we are going to be considering reducing the costs of Medicare.

If we do cut either the aggregate amount or in trying to reduce the aggregate amount, do you think that we should and focus, from your observation, on various services that we can identify as being extremely high priced, or should we just apply across-the-board cuts? And I am thinking on a very short-term basis. I think in the long term, try to rifle shot it in would not be appropriate.

But what advice would you offer this committee if we are looking for savings in this year?

Mr. HSIAO. Mr. Chairman, as a taxpayer as well as an economist, I am very mindful of the large Federal deficit and the Gramm-Rudman legislation. Therefore, I realize that a great deal of the Federal legislative activities are driven by budget considerations.

I will say our current study will not be able to yield any real important and useful information to you for this year's budget cycle. However, the method and concept we are using for this study was not accomplished overnight. Actually this work began in 1978. There was a small study that was done in 1978. It was very exploratory and tentative. And then in 1984-85, we were funded by the Massachusetts Rate Setting Commission to make a study for the State. It was still a limited study, but we had produced a set of relative values for a limited number of procedures and services. And that information, I feel very comfortable, can be used to identify perhaps the overpriced services as well as perhaps underpriced services for any short-run Federal legislative initiatives to control physican payments.

Chairman STARK. Thank you very much.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Mr. Hsiao, I am glad to see you. Harvard, as well as Yale, are in the act of advising us on payment mechanisms. Yale did the initial work on the DRGs and you are involved in the RBS.

Mr. HSIAO. We are trying to catch-up with Yale. [Laughter.]

Mr. GRADISON. Some people say I attended Yale, and was educated at Harvard, and there is probably a little bit of truth in that.

I am concerned with regard to the DRG's, that they are not a permanent solution to the hospital reimbursement issue, mainly because I think in time they are going to break down, that we are going to find that we are not smart enough in our computers, and do not have sufficient capacity to be able to come up with a payment mechanism that fits all the hospitals in the country. To be more direct, I am concerned, even after efforts to fine tune the DRG's, that in time we will have inefficient institutions fail because of a faulty reimbursement system, and we will have to move in some unknown future time to a more market driven method of establishing reimbursement for hospitals. This new method might include describing the business we can offer for next year, and taking bids, much as many corporations and insurance companies are doing with their business, under health insurance arrangements.

This leads me to wonder whether in working on the very attractive concept of relative value scales, we may be doing the same thing. Is it wise to pursue and fine tune a system basically that has some of the earmarks of a price fixing scheme for physicians as we already are using a price fixing scheme under the DRG's for hospitals? Or would we be better off following the private sector and trying to negotiate some kind of a PPO arrangement, community by community specialty by specialty, and come up with lists of those physicians for whom we will pay the full price, and pay a lower percentage, if people want to go somewhere else as is happening in the private sector?

There may be one other way to ask the same question. Are we really, in pursuing the relative value scale concept, following the lead of the private sector as it seeks to become a more prudent buyer, or are we off on a temporary tangent?

Mr. **Hsiao**. Yes, Congressman. I think there are several parts to your question so let me try to answer them in turn.

One major question raised by you is could we rely on the competitive market to set prices for physician services. You suggest that maybe that's where we are going with the hospitals eventually.

Whereas, I argued in my oral presentation, which I think most of the students of health care affairs would agree with me, the competitive force in the physician service market is very weak. Hence if you want to rely on the private market, you have to come up with some very innovative measures to make that market competitive. Right now price competition certainly does not exist, nor do I know of any ways to make it so.

The second part of your question is that whether we can rely on regulations to set prices for physicians. Well, we have not invented too many new wheels. For public policy, we basically only have three approaches to manage a system. One is regulation, another is competition, a third option is a mixture of the first two. I think that a relative value scale provides valuable information for regulation of physician payments. But it also provides information for competition. Let me illustrate.

The most frequent calls I receive are not from insurance companies or even from HCFAs, but are from PPOs and from HMOs. PPOs want objective information to negotiate with physicians and HMOs want reliable information to set up productivity standards for physicians, or to measure when a doctor is overworked or when a doctor is underworked. These objective information are absent today.

Therefore, the relative value scale based on resource cost is a fundamental building block in rationalize the compensation of physicians—regardless how you go, the regulatory route or the competitive route.

Mr. **Gradison**. Well, thanks. That is very helpful because it suggests to me at least the possibility that once such data are available, we could relate them to what is being paid in a given market area.

In my community, for example, Medicare should check the private sector for particular procedures, just to make sure it does not end up the high payer. I am not suggesting we should be the low payer. But I just do not want us to end up by sticking to some archaic reimbursement scheme, as I think we do to some extent today, paying more than the Blues or General Motors pays for comparable services, often from the same physicians, because there are many physicians that will have two or three different reimbursement schemes that they work under depending upon the mix of their own practice.

Thank you.

Mr. DONNELLY [presiding]. Mr. Moody.

Mr. MOODY. No questions.

Mr. DONNELLY. Mr. Levin.

Mr. LEVIN. Just to follow up Mr. Gradison's question, as an economist, what is the argument on the other side? If you were to strengthen competitive forces, say, to have adequate numbers of physicians go in underserved areas, would you perhaps pay them bonuses or perhaps let them advertise and compete, is that the other approach?

Mr. HSIAO. The other approach, I think, requires probably more than just offering bonuses and consumer information.

In my opinion, it requires effective bargaining from the buyers. That is because as a lay person I certainly do not have adequate information or knowledge about medicine and disease. When I go to a physician I rely on his or her professional judgment as what I ought to do, or what kind of treatment I should receive. Therefore, the basic element of competitive market; namely consumer sovereignty, is very weak in the physicians' service market because patients go to physicians for advice and diagnosis and rely on physician's decisions for treatments.

Therefore, to make this market a competitive one, there has to be effective decisionmaking by the consumers. That is the experience throughout the world. It is not just the United States.

Mr. LEVIN. Is anybody using the kind of model that you are exploring? Is there any system that utilizes it?

Mr. HSIAO. I am only aware of a few nations that use bargaining as a method to set physician payments payments. Some nations such as Taiwan where the Social Security system insures the health services of the beneficiaries, bargain with physicians for fees on behalf of their beneficiaries.

Mr. LEVIN. Do they use your model like this, a relatively value scale approach?

Mr. HSIAO. I am not aware that any nation has used a relative value scale. The bargaining with physicians starts without any solid information. Most nations begin the bargaining with what the physicians are charging. This practice institutionalizes the distorted prices that exist in the current markeplace.

You might be interested. I have right now some postdoctural fellows from foreign countries such as Taiwan and Japan to learn about the studying under me resource-based relative value. These nations are trying to move away from charge-based payment systems. They want to have an objective base from which to negotiate with physicians to establish a fee schedule.

Mr. LEVIN. They want to do this in a new territory really.

Dr. HSIAO. Yes.

Mr. LEVIN. One last question then.

Do you think the system is equally adaptable? On page 4 of your testimony, you say a rational basis is needed regardless of whether we compensate physicians on a fee for service basis, physician DRG, negotiations or capitation.

You do not think a relative value scale approach would point more clearly to one system or another?

Mr. HSIAO. I do not think the resource base relative value scale necessarily points to one system or another. What it does is to make the fee schedule approach more feasible immediately. Put it, another way, the resource based relative value scale make it viable to establish a fee schedule on a rational basis.

You need a relative value scale based on objective information whether the United States uses a fee schedule, a global fee or capitation, I think the unit of payment can be handled as a separate policy matter.

Mr. LEVIN. Thank you.

Mr. DONNELLY. Mr. Moody, did you have a question?

Mr. MOODY. Yes, sir.

Mr. DONNELLY. All right.

Mr. MOODY. Dr. Hsiao, I find your testimony very interesting although I had to be out of the room for a few minutes.

Let me ask you, in devising a system that you are working on, how will you get down to some basic unit? The philosophy is that you want to have resource cost base pricing rather than demand base pricing, based on nonmarket and monopolistic market structure.

How will you get down to the basic resource unit? Is it an hour of a physician's time, because that embodies so much human capital and is so different between one doctor and another, between one specialty and another? What is your basic accounting unit going to be? Is it an hour of medical schooling required to produce that human capital, because it might take sixfold difference in that basic unit to produce one output unit of a doctor's time? How will you denominate?

Mr. HSIAO. Congressman Moody, the basic denominator we have is an unit of time. But the time is adjusted for its intensity. As I explained earlier in my oral testimony, that intensity encompassing the technical skill, the mental effort, judgment, stress, iatrogenic harm, and other elements.

But, in addition, it is not just the unit of time, but it is the unit of time weighted by the intensity of effort. We also adjust for the human capital, as you put it. That is, how much postgraduate training is required for a specialty. That is a very crude measurement, and we do not differentiate the length of training required to perform a given procedure and services within a specialty, only differentiate between specialties.

So, a specialty that requires 5 years of postgraduate training will receive higher rates for each unit of their time than, let us say, a specialty that only requires 3 years of postgraduate training. And that is how we capture the different values of human capital.

Mr. MOODY. I can see how the human capital might be quantified because it is acceptable to cardinal measurement.

Mr. HSIAO. Yes.

Mr. MOODY. But when you are weighing the unit of doctor's time by, as you say, intensity, by stress, by some of the other instances, I can see how you get an ordinal measurement maybe, but how can you get the cardinal measurement that does not require tremendous amounts of judgment, and subjective judgment at that?

Mr. HSIAO. Your question is so perceptive and intelligent, I really would like to make an offer. If you ever want to retire from Congress, will you consider joining our research team. [Laughter.]

Your question precisely focuses in the methodological problem of doing this kind of research. How do you measure intensity, and can you measure intensity? We went into this study with certain skepticism. We were not sure.

And just to illustrate how complex this problem is, the type of people engaged in this study includes statisticians, economists, medical clinicians, measurement psychologists and sociologists. Through collective efforts, we designed a measurement method to measure intensity. We did not know how reliable it would be and whether we have measured the right thing? That is one reason why we work so closely with the physicians. First, we tried out our methods on our technical consultant panel members.

We also interviewed in depth roughly throughout the course of this whole study, more than 50 physicians on a face-to-face basis for more than an hour. And we tried out different methods to see which one really gives us the most reliable results.

Then we selected the best method and tried it with a larger group of doctors to see whether they can give us a reliable cardinal measurement of intensity. I am happy to report to you that there is agreement on the rating of intensity among physicians. Actually that agreement is quite tight. In other words, we can obtain reliable estimates by interviewing roughly only 50 physicians across the United States in a given specialty.

Second, we now also understand what makes up intensity. I had earlier enumerated the elements of intensity for you. That included technical skill, physical and mental effort, judgment and stress. Those are the components of intensity.

We were not only able to decompose intensity, but also conducted validity tests.

If you spoke to me 6 months ago, I would have waffled all over the place. Now I am much more confident on our method and on the reliability of the measurement of the intensity.

Mr. DONNELLY. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Thank you for your testimony and the work that you are doing for the Congress in this area on this whole issue.

In your testimony, you pointed out that there can be a widespread variety of 200-percent difference in the amount of money that one physician would charge in the same community for an office procedure. And, further, that one of the reasons might be that the caseload is lighter for one doctor than the other.

I wonder if you could elaborate and say further is that as a result of newness to the profession, or what would further cause the variation of 200 percent in one doctor's fees from another in the same community?

Mr. HSIAO. There are different possible explanations, Congressman. I would be misleading you if I tell you we know precisely what explains these variations. There are only different hypotheses, and each one has some empirical support for it.

One of the possible economic explanations for these wide price variations in a marketplace is that the price competition is very weak; the price varies because people do not know the price and they do not shop for services based on price. That could explain why the price varies for the same service. And variation is two to threefold.

The second explanation that most of us think there is some validity is that physicians often have the ability both in setting the price and determining the volume of their work. When the patient population is limited, physicians' ability to set a volume of their work is limited. After awhile then, in order to achieve a desirable level of income, physicians will raise their fees. Earlier, committee members asked as how do you control both the price and volume? This question was raised because we observed that there is a displacement effect. That is, when you control the price, we see a displacement on the volume side. When the volume is controlled, then we observe the price goes up and out of control.

Let me offer an illustration, New York City and its Westchester County, or Los Angeles area, the number of physicians per capita is about three times of the average of the Nation. And their charges, interestingly, is usually about two to three times as high as the average of the Nation.

Mr. COYNE. On another subject, were there any specialty groups that did not participate when you asked the different groups to visit with you in Boston?

Mr. HSIAO. No. All the specialty groups participated as specialties. But one organization did not participate when it was asked. That is the American College of Surgeons. The American College of Surgeons was approached by both the American Medical Association and by us indirectly. Their board of regents decided that they would not participate in the study. I noted on your schedule that the executive director of the American College of Surgeons is going to testify later. You may wish to get some direct testimony about their reasons.

I want to assure you however, that although the American College of Surgeons, an umbrella organization, decided they would not participate, the surgical specialties, which are a part of the American College of Surgeons, have participated. And so we have the cooperation and the advice from the surgeons.

Mr. COYNE. Thank you very much.

Chairman STARK. Doctor, I am sorry I had to absent myself during the inquiry here. But I appreciate your testimony and the work you have done.

As with Dr. Lee, we will probably call on you for help as we proceed during this year to try and both meet our budget goals on the short term and revise or make changes in the payment procedures for physicians in the long run.

Thank you very much.

Mr. HSIAO. Well, Mr. Chairman, I want to express my thanks to you and the committee members. Also if there is anything we can be of assistance, we are more than glad to do that, as well as we want to make sure that Yale is not the only school giving you advice. [Laughter.]

Chairman STARK. Our next panel consists of Dr. William Stason, the director of Health Systems Research and Development, Northeast Region, the Veterans' Administration, from the West Roxbury

Veterans' Hospital, and Dr. Benson Roe, professor of surgery at the University of California and San Francisco Medical Center.

It is my understanding that you are going to lead up through four choices for the fiscal year 1988 budget options, and I guess this is a question of angels rushing in where fools fear to tread.

I will ask you to proceed in the order of Dr. Stason, first, and you may expand on your testimony, or summarize it, or proceed in any manner you are comfortable with.

STATEMENT OF WILLIAM B. STASON, M.D., DIRECTOR, HEALTH SYSTEMS RESEARCH AND DEVELOPMENT, NORTHEAST REGION, VETERANS' ADMINISTRATION, WEST ROXBURY VETERANS' ADMINISTRATION MEDICAL CENTER

Dr. **Stason**. Thank you very much, Mr. Chairman.

My name is William Stason. I am speaking here today as an individual, and very clearly not as a representative of any group or institution.

I was a colleague of Dr. Hsiao's during the initial development of the resource-based relative value scale, and therefore am conversant with its elements.

Fundamental reform in the way physicians are paid is overdue. The usual, customary, and reasonable system is complex, inflationary, and, in many ways, inequitable. The creation of a relative value scale represents the best way, in my view, to simplify the physician payment system, and, at the same time, address the discrepancies that exist. In particular, a resource or a cost-based relative value scale has the best potential to provide the level ground that will be needed as a cornerstone for reform. Though it should be acknowledged, I believe, costs are only one measure of value of medical services, and it may be wise to consider other factors such as expected health benefits in ultimate decisions on a fee schedule, resource costs do provide a useful starting point.

There can be little question—and this has been mentioned several times this morning, that procedures, diagnostic as well as operative, are rewarded disproportionately to so-called purely cognitive medical services.

Further, there is little question that some procedures are over priced relative to other procedures. Dr. Janet Mitchell and I have examined this latter question by comparing 1984 Medicare part B claims in four States—Alabama, Connecticut, Washington, and Wisconsin—to the resource-based relative value scale developed by Dr. Hsiao and his colleagues in Massachusetts.

In this study, we used cholecystectomy as the referent procedure. Cholecystectomy was selected for this purpose because it is a commonly performed procedure, is generally elective in nature, and represents a stable technology.

By this standard, we found overpayments for several operative procedures that are commonly performed in the Medicare population and account for——

Chairman **Stark**. Could I interrupt, assuming that it is not too close to lunch for me to know, what this procedure is in a sense that I would recognize it.

Dr. **Stason**. A gall bladder operation.

Chairman **Stark**. Removal?

Dr. **Stason**. Removal of the gall bladder.

Chairman **Stark**. OK. Thanks.

Dr. **Stason**. The procedures that we focused on account for a significant proportion, perhaps as many as 10 percent of Medicare payments to physicians.

We found that overpayments by the resource-based relative value scale standard ranged from 13 percent for treatment of a fracture of the femur, the upper bone in the leg, to 63 percent for a cataract extraction with intraocular lens insertion. Other procedures that appeared to be overpaid include open-heart surgery, pacemaker insertion, hip replacement, and prostatectomy. Estimated cost savings to the Medicare program, based upon 1984 fees and 1984 hospital discharge rates, if cost-based fees were fully implemented, amount to something in excess of $700 million per year. Savings would obviously be less if these resource-based fees were only partially implemented.

Any consideration of changing fees based upon these results should take into account the early stage of development of the resource-based methodology.

Nonetheless, the directions for the reform are clear, and the changes suggested by our study are conservative in several important respects. First, our study used another surgical procedure as the basis for comparison, and thus avoided the difficult issues of comparing procedures to purely cognitive services. Second, our figures underestimate savings to the extent that 1987 physician fees are greater than those in 1984, and to the extent that there has been continued growth in the frequency of operations in elderly persons available evidence suggests that these trends continue. Third, volume estimates based upon hospital discharges understate the true frequency of some operations such as lens extraction which, increasingly, is being performed on an ambulatory basis. Finally, savings would be greater if fee adjustments were extended to other operative procedures, overpriced diagnostic procedures such as colonoscopy, and to common small-ticket medical services such as electrocardiogram or x ray interpretation.

National studies are much needed to provide a more secure basis for physician payment reform. Dr. Hsiao's study at the Harvard School of Public Health is the major effort in this regard. A second study, "The Physician Practice Follow-up Study", will, I believe, also contribute valuable information. This study is being conducted by the National Opinion Research Center, is with funding from ASPE and HCFA, is collecting information from over 3,500 physicians in 13 medical specialties on the time and complexity of a wide variety of medical services. And you heard earlier, these are the essential components of a cost-based relative value scale. Results of this study will be available later in 1987.

Physician payment reform, in my opinion, should consider issues other than cost containment and possible inequities among current fees. Effects on out-of-pocket costs to patients, patient access, and quality——

Chairman **Stark**. If I could interrupt the witness just for a minute. We have a vote but we would like to continue, and we will kind of zip and take turns going to vote. So just proceed, and excuse us for the——

Dr. **Stason**. I am almost finished.

Chairman **Stark**. Go right ahead. And Dr. Roe, if you will just follow right on, we will get back.

Dr. **Stason**. So I feel that these issues that directly affect beneficiaries are vital concerns as well, as we consider physician payment reform. Incremental reductions in fees for selected overpaid procedures might test the waters on each of these beneficiary issues while achieving some short-term cost savings. Any changes that are made, however, should be made with full cognizance of their risks, and with a commitment to monitor carefully any adverse effects.

[The prepared statement follows:]

TESTIMONY OF WILLIAM B. STASON, MD

to the

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

MARCH 3, 1987

My name is William Stason. I am speaking here today as an individual and not as a representative of any group or institution.

Fundamental reform in the way physicians are paid is overdue. The usual, customary, and reasonable (UCR) system is complex, inflationary, and, in many ways, inequitable. The creation of a relative value scale represents the best way, in my view, to simplify the physician payment system and at the same time address the discrepancies that exist. In particular, a resource-based relative value scale has the best potential to provide the 'level ground' that will be needed as a cornerstone for reform.

The relative value scale (RVS) approach, in general, has several significant advantages over other reform options. First, a RVS would be easy for the consumer and health professional alike to interpret and easy for Medicare to administer. Second, a RVS separates decisions on the value relationships among medical services from decisions on monetary levels of reimbursement. Hence, decisions on geographic variations in payments or cost - containment imperatives can be kept distinct from decisions that relate to medical inputs or health benefits. Third, a RVS can be as important to determining reimbursement levels under capitation or salaries as it can be under fee-for-service reimbursement. Both capitation fees and salaries, ultimately, are composed of bundles of individual services. A RVS will establish the relative prices of these services.

There is little question that procedures, diagnostic as well as operative, are rewarded disproportionately to so - called purely cognitive medical services. Furthermore, there is little question that some procedures are "over-priced" relative to other procedures. The resource (or cost) based RVS approach directly addresses both questions.

The first RBRVS developed by Dr. Hsiao and me identified at least two - fold, and often greater, discrepancies between charges for office visits and a variety of operative and diagnostic procedures. These findings were verified in a subsequent larger study by Dr. Hsiao and his colleagues. Discrepancies of these magnitudes are difficult to ascribe to any vagaries of the RBRVS methodology.

More recently Janet Mitchill, PhD, and I have examined the narrower question of whether Medicare currently "overpays" for some procedures relative to other procedures. To examine this question we compared 1984 Medicare Part B claims in four states (Alabama, Connecticut, Washington, and Wisconsin) to Dr. Hsiao's resource-based relative value scale for Massachusetts. In this study, we used cholecystectomy without common bile duct exploration as the referent procedure. Cholecystectomy was selected for this purpose because it is a commonly performed procedure, is generally elective in nature, and represents a stable technology.

By this standard, we found overpayments for several operative procedures commonly performed in the Medicare population. These overpayments ranged from 13 percent for a femoral fracture treated by open reduction and internal fixation to 63 percent for a cataract extraction with intraocular lens insertion. (See attached table) Estimated cost savings to the Medicare program based on 1984 fees and 1984 hospital discharge rates, if the RBRVS-suggested fees were fully implemented, amount to 775 million dollars per year. Savings would obviously be less if RBRVS fees were only partially implemented.

Any contemplation of changing fees based on the RBRVS should take into account the early stage of development of its methodology. Nonetheless, the directions of reform seem clear, and the changes suggested by our study are conservative in several important respects. First, our study used other surgical procedures as the basis for comparison and thus avoided the difficult issue of comparing procedures to purely cognitve services. Second,our figures underestimate savings to the extent that 1987 physician fees are higher that those in 1984 and to the extent that there has been continued absolute and relative growth in the frequency of operations in elderly persons. Third, volume estimates based on hospital discharges understate the true frequency of operations such as lens extraction that are frequently performed on an ambulatory basis. Finally, savings would be greater if fee adjustments were extended to other operative procedures or to common "small ticket" medical services such as electrocardiogram or x-ray interpretation.

National studies are needed to provide a more secure basis for definitive physician payment reform. Dr. Hsiao's is the major effort in this regard. A second study, The Physician Practice Follow-up Study, will also contribute valuable information. This study, which is being conducted by the National Opinion Research Center with funding from Department Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation and the Health Care Financing Administration, is collecting information from over 3500 physicians in 13 medical specialties on the time and complexity of a wide variety of medical services. At the same time it is also obtaining information on changes between 1983 and 1986 in physician practice arrangements, malpractice insurance premiums, and Medicare participation rates. Results of this study will be available in late 1987.

Physician payment reform should consider issues other than cost-containment and possible inequities among current fees. Effects on out-of-pocket costs to patients, access to needed care, and counter-productive effects on physician incomes also need be considered. Incremental changes for selected "overpaid" procedures might test the waters on each of these accounts while achieving short-term cost savings. Any changes that are made, however, should be with full cognizance of their risks and with a commitment to monitor carefully any adverse effects.

POTENTIAL COST SAVINGS FROM THE APPLICATION OF RESOURCE-BASED RELATIVE VALUES TO MEDICARE CHARGES FOR SELECTED HIGH VOLUME OPERATIVE PROCEDURES

PROCEDURE	DISCHARGES IN 1984 FOR PERSONS 65 OR OLDER [1]	MEDICARE REASONABLE CHARGES IN 1984 [2]	PERCENT REDUCTIONS BY RBRVS [3]	POTENTIAL COST SAVINGS IN MILLIONS
Cholecystectomy (index procedure)	145	$714	0.0%	0.0
TUR	248	1013	-36.0	90.5
Total abdominal hysterectomy	34	825	-20.2	5.7
Total hip replacement	141	2040	-44.9	129.2
Femoral fracture with open treatment and internal fixation	102	1105	-12.9	14.5
Pacemaker insertion [4]	133	854	-38.9	44.2
CABG (3 bypasses)	71	3666	-32.7	85.1
Lens extraction, intracapsular [4]	163	987	-51.4	82.7
Lens extraction [4] intracapsular with IOL insertion	353	1444	-63.4	323.2

1. Discharges from Short-Stay Hospitals in the United States in 1984 in thousands.

2. Average charges calculated from 1984 Part B claims in Alabama, Connecticut, Washington and Wisconsin.

3. Calculated from resource-based relative values estimated by Hsiao, et. al. in Massachusetts in 1985.

4. Underestimate numbers of procedures performed, and hence potential cost savings, to the extent that procedures were performed on an ambulatory basis in 1984.

STATEMENT OF BENSON B. ROE, M.D., PROFESSOR OF SURGERY, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO MEDICAL CENTER

Dr. Roe. Mr. Chairman, I presume that my presence here is for the purpose of providing you with the perspective of a surgeon with a long list of leadership responsibilities and four decades of surgical practice, which encompasses both independent private practice and academia, which experienced the pioneering and development of cardiac surgery, and which benefited from the transition from earning a living from patients' thin pocketbooks, or meager indemnification policies, to the cornucopia of third-party agents paying supposedly usual, customary, or reasonable fees.

What expertise I have in medical economics derives from 10 years as a claims consultant for California Blue Shield where I became appalled by what I saw. It provoked me to write a series of articles with which your staff seems to be familiar.

The well-intended but totally impractical UCR system, in my mind, is the most easily correctable of the four major causes of runaway health costs.

This law mandated fee variations for supposed differences in skill and experience, and for supposed differences in the cost of practice.

However, it provided no mechanism to monitor or verify these differences, and no definitions of responsibility to be encompassed by a given service. Thus it opened the door for escalation, exaggeration, and unbundling, which led to exorbitant billing.

These potentially controllable abuses were largely ignored by the disbursing agencies, who should have implemented the implied policies and curtailed unreasonable payments. But they never did.

Inflationary consequences were compounded by establishing the payment ceiling at the 80th percentile of the local charges instead of the more reasonable 50th percentile.

Current inequities and injustices in remuneration have evolved because some providers have billed more aggressively than others, and because payments for new procedures were never adjusted after initial risks and innovative demands had passed.

In short, the system literally invited abuse. Abuses were never controlled and gradually became the standard practice. Consequently, you can be sure that any corrective measure no matter how sensible will evoke loud objections. Take the candy jar away from the gluttonous child and he will scream.

Correcting these deeply rooted deficiencies will obviously be a slow and complicated process, and I am delighted with the reports of Dr. Lee's commission, and Dr. Hsaio's committee. They are making excellent progress in this difficult challenge. It will not be easy to rectify these unreasonable differences in payments, particularly between procedural and non-procedural services, the most exaggerated of which is a cataract surgeon I know who bills in excess of $9,000 for an hour's work, and a pediatrician who can bill between $50 and $75 an hour. These discrepancies exaggerate any differences in skill and demands on the individuals involved.

On the other hand, immediate major economies, perhaps up to 20 percent, can be derived from specific constraints and some basic ground rule changes.

Under constraints, I suggest addressing the leading cost items and identify those deriving from obviously disproportionate fees that are significantly greater than fees for comparable services. As suggested by others, such a list includes cataract extraction, coronary bypass surgery, coronary artery balloon angioplasty, hip replacement, pacemaker implantation, and certain dermatological procedures. Payment ceilings for that list of procedures, can be arbitrarily cut somewhere between 10 and 20 percent for starters.

In sharp contrast to the nonprocedural providers, many of whom are operating on a marginal profit basis, the busy and successful providers of the aforementioned list of services would suffer no more hardship with a 20 percent cut than perhaps missing a second Rolls Royce.

Under ground rules, I have attached a list of tenets and explanations for your staff. They simply eliminate unreasonable discrepancies and redefine the scope of a given service along traditional lines to make it encompass the elements that have become insidiously unbundled.

The thrust of its proposals is to standardize remuneration countrywide and define that remuneration to cover everything.

Specifically, I would eliminate geographical differentials because the existing differentials do not correlate with practice costs. And do away with local fee differentials because they do not correlate with skill and experience.

There are also good reasons for eliminating virtually all supplemental charges for difficulty and complexity, for adjunctive procedures, and for taking care of all complications.

If these simple and noncontroversial steps were taken, large savings would result, not only from the eliminated supplements, but also by simplifying the claims review process and its overhead cost which is considerable.

Despite the inevitable squawking, I do not believe that any of these steps could be reasonably accused of impairing the quality of care, and I am confident that the responsible members of my profession will accept these policy changes, particularly if they are appropriately endorsed and explained to them.

[The prepared statement follows:]

TESTIMONY OF BENSON B. ROE, M.D.
HOUSE OF REPRESENTATIVES - WAYS & MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH

Mr. Chairman and Members of the Committee:

I come to you as a surgeon whose 44 years of practice has spanned both the private sector and academia. As a cardiac surgeon, who participated in the development of that specialty from its beginning, I experienced the metamorphosis of physician remuneration from the patients' limited pocket book or meager indemnification coverage to the cornucopia of third party agents who pay supposedly "Usual, Customary or Reasonable" fees (the U.C.R.system). My knowledge of the problem at hand has been expanded through 10 years experience as a claims consultant for Blue Shield of California, where I witnessed the evolution of current excesses.

The well motivated but totally impractical U.C.R. system is the most evident and certainly the most correctable of the four major reasons why medical care costs have run wild.*

The law mandated variations in fees for supposed differences in skill and experience and for differences in cost of practice, but it did not provide any mechanism to monitor or to confirm these differences. In addition the law did not define the scope of responsibility covered under the label of a given service. These defects opened the door for services to be exaggerated and unbundled, and thus for exhorbitant billing.

Those who administered the remuneration process neglected their responsibility to interpret policy and to prevent unreasonable payments. The problem was compounded by adopting the predictably inflationary policy of paying up to the 80th percentile of local charges instead of the more realistic 50th percentile.

Over the 22 year history of U.C.R. and Medicare these characteristics have led to serious injustices and inequities both because some groups of providers have billed more aggressively than others and because payments for new procedures have never been adjusted to a rational level after their initial high risk and innovative demands have passed.

The system virtually invited abuse. And because abuses were never brought to account and contained they became accepted as part of standard practice. You can be certain, therefore, that any measure—even an obviously sensible measure—to correct these abuses will meet with strong objections. Take the candy jar away from the gluttonous child and he will scream!

It will not be easy to correct these deeply rooted deficiences. Obviously the job will have to be done in stages. The most difficult part will be agreeing on a process to rectify the unreasonable price differential between procedureal services and nonprocedural services, the most extreme of which is the $9000/hour charged by a cataract surgeon and the $50-75/hour charged by the pediatrician. Dr. Hsaio has told you about how that subject is being tackled by the joint Harvard-A.M.A. project.

Curtailing overutilization and blank check attitudes derived from a non competitive support system will also require some difficult fundamental changes. That issue is being addressed in part by the D.R.G. system.

On the other hand economies of substantial magnitude—perhaps as much as 20% of physician charges—can be achieved immediately with only a few specific constraints and a handful of basic ground rule changes, without waiting for a revision of the current remuneration system.

In the category of specific constraints I suggest screening the leading cost procedures for the items which are charged at a level clearly out of line with other comparable services. Among such services are cataract lens replacement, coronary artery bypass, coronary artery balloon angioplasty, hip replacement, pacemaker implantation, and some simple dermatological procedures. In sharp contrast to the providers of non procedural services, successful providers of the aforementioned procedures could sustain a 20% cut without depriving them of much more than a second Rolls Royce.

In the category of ground rules I have attached a proposal—with appropriate explanations—for eliminating unreasonable and unjustifiable discrepancies in whatever new remuneration system is adopted. Its thrust is to redefine services to conform with traditional values, which included the unbundled and accessory elements in current billing.

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*Expensive technology, ageing population, lack of competition, and U.C.R.

These tenets propose:

(1) That remuneration for all services should be standardized country-wide (with exceptions to be separately justified and sharply defined). This measure is supported by virtue of the established facts that:

a. Differentials in current fees between geographic areas do not correlate with variations in practice costs between those areas and have no other demonstrable basis for their existence.

b. Differentials based on alleged skill and experience are unmeasurable and unverifiable. Current fee differentials between providers do not correlate with evidence of these attributes.

(2) That remuneration for a major procedure should encompass a broad scope of responsibility for all of its arbitrary and unpredictable aspects that cannot be objectively verified and evaluated. Thus supplementary charges should be eliminated:

a. For difficulty or complexity, because these are purely subjective and unverifiable values. What is easy for one may be difficult for another, and there is no rationale for rewarding the latter.

b. For adjuncts, accessories and supplemental procedures in conjunction with a major operation because electing these elements is largely arbitrary and they frequently serve primarily the surgeon's convenience.

c. For problems and complications because they are just as likely to arise from flawed technique or flawed judgment on the part of the provider as they are from the inherent disease of the patient. Rewarding potential incompetence is irrational.

Application of these measures should not be difficult because they merely represent the principles that were implied in the original Law but were never properly enforced. Because a major portion of current remuneration cost is the result of the surcharges for unnecessary supplemental or unbundled services and for exaggerated complexity, the elimination of these elements will result in significant savings. Additional savings will result from removing the administrative expense of screening, adjudicating and litigating these items in the claims review process.

There is no reason to expect that either quality or accessability of care would be impaired by the imposition of these policies because they merely restore practices that were customary before the days of third party remuneration.

I am confident that responsible members of my profession will consider these measures to be fair and reasonable.

March 3, 1987

A SYSTEM OF SURGICAL REMUNERATION
Practical Considerations
by Benson B. Roe, M.D.

Third party remuneration for surgical procedures is currently fraught with irrational inequities, excesses and abuses. Measures to correct these deficiencies and to restore fiscal integrity must be realistic and workable, which the present system is not. The process must identify and address those factors that can be recognized, monitored and quantified. Subjective factors that cannot be measured must be eliminated because any system that allows for manipulation and loose interpretation is destined to certain failure.

1. Differentials between surgical specialties—as practiced by certified specialists—are possible to factor. Although these differences involve subjective values, it is conceivable that experienced representatives from each specialty can negotiate a ratio of comparable effort value on the basis of (a) training requirements to practice the specialty, (b) the degree of technical precision required, and (c) the magnitude of risk involved. Ideally there should be a unified R.V.S., to which a single dollar factor can be applied and modified from time to time.
*[This issue is complex and politically difficult to resolve. Dr. Hsaio's project with Harvard and the A.M.A. and Dr. Lee's Commission are both attempting to address it. The process will be long and tedious.]

2. Differentials between generically defined procedures within each specialty have already been established on the basis of usual time, effort, responsibility and skill required (vis-a-vis the California R.V.S.). These differentials may need improving and updating; however, this is a detail that can be worked out within each specialty and should not concern central planning.
*[The one area deserving immediate attention is that of procedures that were assigned high values when new and undeveloped. Now that they have become routine, these values should be reduced to a realistic level of older procedures requiring similar time and effort.]

3. Differentials for difficulty or complexity between individual cases within a single generic definition are impossible to factor. These characteristics are subjective, unmeasureable and unverifiable. ("What is easy for one may be difficult for another.") Differentials should be absorbed by averaging and determining remuneration on the basis of the mean or median difficulty of each procedure. These factors are the source of uncontrollable, unnecessary and even fraudulent charges.
*[Objections to this ruling can be addressed by the established fact that charges are almost never reduced below "usual" for simpler or easier cases at the other end of the spectrum.]

4. Differentials in skill and experience between individual surgeons are impossible to factor. Of course surgeons are not equal but there is no way to measure or verify the differences. Unusual skill is rewarded as a market force in attracting patients and by charges to private patients outside the system. Skill is also rewarded by reducing the time and effort required to earn the standard compensation for the procedure.
*[Objections can be addressed by pointing out that current fee differences have evolved without demonstrable correlation to skill and experience. Indeed, fee differences may even correlate negatively.]

5. Differentials in practice costs between urban-rural or different geographic locations are very difficult to quantify because there is no standard by which to measure. The spread between chosen styles of practice overlaps the spread between basic costs in different locations. (Luxurious offices, expensive cars and excessive services can multiply overhead.) Practice cost may serve as an economic force in the distribution of surgeons. It probably should not be factored into the remuneration system, except perhaps for the cost of malpractice insurance.
*[Current major geographic differentials in fees do not correlate with practice costs and providers have never been required to substantiate higher costs before being paid a fee above the national average. A universal remuneration scale can provide for regional adjustment when and where cost increments are substantiated with satisfactory evidence.]

6. Adjuncts, accessories and supplemental procedures in a major operation should not warrant additional remuneration. The use of these adjuncts is usually discretionary and it is impossible to determine whether or not they were necessary. The need for them may even reflect incompetence. Furthermore, added remuneration motivates unnecessary utilization. Therefore, standard remuneration for a procedure should be sufficient to encompass the usual incidence of needing those adjuncts.
*[A wide variety of surcharges are being submitted for various monitoring devices, technical adjuncts such as Lasers and staples, and minor extensions of the operation.]
7. Complications following a procedure should all be managed without additional remuneration Complications derive either from the patient's underlying condition or result from flawed technique or flawed judgement of the physician. It is almost never possible to differentiate between these causes. Therefore, any extra effort or even a procedural intervention for complication or bad result should properly be part of the total operative responsibility and be encompassed in its remuneration.
*[The present widespread custom of billing additionally for services to manage complications is a large cost factor. It is basically unfair because it rewards the less competent, who have the most complications.]

Elimination of these differentials will result in underpayment in some instances but compensatory overpayment will occur in others if the remuneration is based on the average effort of the competent surgeon. The more skilled and adroit will be indirectly rewarded and the clumsy will be indirectly penalized,- both without judgmental involvement.

Application of these tenets to a single, nation-wide remuneration scale for patients under public subsidy will materially reduce costs through 3 mechanisms—even without reducing the average existing payment scale:
(1) Claims review will be greatly simplified, which will reduce the cost of administration.
(2) Fraudulent or exaggerated claims will be largely eliminated. Currently a large proportion of these questionable claims are escaping attention. When they are caught it is usually difficult to ajudicate the issue and sometimes the process leads to expensive litigation.
(3) Payment for (frequently unnecessary) adjunctive procedures, complications and irrational differentials will be eliminated.

* Footnotes for Committee.

San Francisco CA
2/23/87

Chairman **Stark**. Thank you. Dr. Roe, I missed your testimony and I was looking through it here, just before I left for the vote. I just wondered if—judging from the tenor of your testimony—if either of you gentlemen have applied to the Federal marshal's office to participate in the Federal witness program. [Laughter.]

But what you have said in your testimony is something that many of us have been concerned about, and that is lacking any technical competency to even question, and having been brought up, as I am sure you both were, to know that you basically did not question your family doctor whether it was approach procedures under instrument conditions, or whether it was family planning, or what was wrong with you.

And that makes it difficult for us, sometimes, when we make these challenges, and often, it has been my experience that the standard response to changing the method of payment, or the amount of payment that we get is, well, what about quality?

And I generally did not think we were talking about quality. We were just talking about how much money and for what one presumed to be quality care. But I think that your approach is so very refreshing and I would like to ask you to remain here, if I can, until my colleagues return.

I just think that if we could have more willingness from the professional providers of Medicare to negotiate with us, we could both help the system and provide a reasonably decent, if not in many cases, obscene standard of living for your colleagues.

What is the risk, Dr. Stason, if we reduce payments on some of the surgical procedures that you identify, both in your statement, and referring to Dr. Hsiao's studies—to access and quality? I mean, there must be some areas at which people say I am not going to do that anymore.

I have not noticed all kinds of physicians fleeing Massachusetts in the past year, but that has always been a threat that I have heard. If you do this, people will not be able to get care. Well, there are two issues. One is just the absence, the availability. For example, take rural areas, underserved areas.

And the other question is, what is the danger of people providing less than full quality? It seems to me those are almost separate issues. Can you comment on that a little bit, because that is where we are always challenged. Now what about those two, the quality or access.

Dr. **Stason**. I do not think anyone can say with certainty what will happen, and that is why, in my testimony, I made the suggestion that any steps that are taken to reduce fees be carefully monitored to ensure at least that access is not compromised.

I cannot believe that the modest 10- to 20-percent reductions in the prices of certain overpriced procedures that Dr. Roe and I are proposing, will significantly affect physicians' practice patterns or restrict access.

It is even harder for me to believe that reductions of this sort would in any way affect quality. I believe staunchly in the ethics of the medical profession and that most of my colleagues will perform at their highest capabilities regardless of the reimbursement level, at least within some bounds of reason. A 10- to 20-percent reduction of fees for these procedures is, well within bounds of reason.

Chairman **Stark**. I guess the answer is that if you are down to, on the margin, you are not going to reduce access. The question is, do you get to a point where there is no margin, where you have one doctor for a community, and there is no marginal number of practitioners. You either have a doctor or you do not.

And I suppose that the issue is, can you replace those underserved areas with alternate forms? For example, better transportation, communication, nurse-practitioners, alternate forms of providing the service. Dr. Roe, did you want to comment on that at all?

Dr. **Roe**. Yes, Mr. Chairman. I think I can say with even greater confidence, that you will not have one whit of reduction in either access or quality.

This is not just based on the moral caliber of my profession, but it is based on simple economics. If surgeons had to sustain the cost of running the operating room and paying the patient's hospital bill, there might be a bottom line that would limit their ability to take a patient.

But surgeons like to operate—except maybe for Wednesday afternoons—there is nothing else they would rather be doing. Many would operate if they did not get paid at all.

Chairman **Stark**. Really? [Laughter.]

Dr. **Roe**. So that I am quite confident that these reductions would be accepted. Naturally nobody likes to have his paycheck cut, but in reality, there will still be plenty of access, and the quality of care will not change one little bit.

Chairman **Stark**. Tell me whether I am going down a blind alley or a street filled with potholes here. But it has occurred to me, that if we could ever get the tension between the payers and the providers below the contention level so we could negotiate, as it were, we might make a lot more progress than just sort of people who have nonnegotiable demands. It seems to me that in a lot of procedures, you have a week or a month, or so, to decide when you go in to have it done.

Could we somehow, as purchasers, whether it is me or Joe Califano purchasing for Chrysler, go to the surgeons specializing in removal of gall bladders and say, look, you could reasonably be expected to do four a day, 20 days a month, that is 80 a month, a thousand procedures a year. But that is all.

Now, if you are only doing 750 to charge, that means you have got 250—you are not filling your schedule. Maybe you want to quit playing golf on Wednesday and you would like to add a few.

Those should not cost you anymore. You already have your office and your nurse, and you have done all the things you have to do. How about if I guarantee you 250 of those procedures a year, and you schedule them so you fill in your offtime, would you give them to me at a 30 or 40 percent reduced rate?

Now, it would seem to me if a doctor really wants to maximize his return on his investment and training, and equipment, he might jump at that chance. Maybe not. Is that unrealistic, to think that there might be some savings in the way that we negotiate, regardless of how it comes out in the relative value of things, but could we be a little more creative, as the buyers, in finding ways to schedule our beneficiaries, for example? Either, or both?

Dr. Roe. Well, that scenario—and not quite the manner in which you presented it—but that scenario was the basis of an article I wrote for "The New England Journal" a couple of years ago.

Chairman Stark. Great minds go in the same direction, do they not? [Laughter.]

Dr. Roe. I do think that there are lots of imaginative approaches that can deal with this problem to reduce the 30 or 40 percent fat in the system that exists, without causing any reduction in accessibility or quality.

But it does have to be initiated, at least for starters, at the simple level of ground rules. Then progress along the lines that Dr. Hsiao and Dr. Lee have developed for a more comprehensive reform of the system.

Chairman Stark. Dr. Stason.

Dr. Stason. In direct answer to your question, I believe physicians, as other people in society, are motivated by an income goal. If there is an alternative way of reaching that goal, such as the guarantee to which you refer, I feel comfortable that many physicians would be more than willing to negotiate.

And I think this will become evermore likely as the physician excess problem, particularly in surgical subspecialties, becomes more evident.

Chairman Stark. The stockbroker, the advent of Boesky, and people like that, anticipated income knows no bounds anymore. But is there a practical limit? I can see it in, say, psychiatry, where generally you can only charge so much an hour, and you have got to be there because the patients will know whether you are there, or not. And you can say it is pretty hard for a psychiatrist at *x* bucks an hour to ever gross more than so many dollars.

And they seem to have a relatively narrow range of charges—but are there practical limits? If a doctor grossing, $300,000, maybe more—is there a limit? I mean, if you want to make more than that, $800,000 a year, you had better start an HMO, or start a pharmaceutical company, or go on television.

Is there a practical limit in most of the specialties, even if you say, look, you have to move to Park Avenue, you cannot practice here in Podunk, if you want to generate $500,000 or $600,000 in fees. You have to be where there are a lot of rich people to pay it.

Even given that, are there caps to this income anticipation? I think most people would never think of it. We think doctors can be as very rich. But as a practical matter, is there a range? I do not read medical economics, but I guess I should and see what these guys talk about anymore.

Dr. Roe. Well, the answer is yes and no, and as I tried to differentiate in my testimony. The nonprocedural provider or the psychiatrist only has so many hours, which puts a ceiling on their income. Their costs of doing business reach a level where they literally cannot afford to take another patient.

But at the opposite end of the scale are those doing procedures, remuneration for which is well into four figures, some of which take only a few minutes. It does not take much arithmetic to demonstrate a seven-figure income. There are quite a few people in that category, not even working at full throttle. These discrepancies are enormous. Thus one cannot generalize from one end of the profession to the other.

Chairman **Stark**. And I mean, the fraternity does not look around and say, hey, guys, that is too much? There is no mechanism among——

Dr. **Roe**. It is partially corrected in the cooperative efforts of the major clinics like the Mayo Clinic and Cleveland Clinic. The big earners share a portion of their earnings with the shorter earners. So they come out a little less steeply differentiated.

But in general this differentiation in the practice of medicine is not equitized, except perhaps to some extent under the table by illegal fee-splitting. Also referring doctors sometimes act as an assistant to collect a big assistance fee, but not really something that he earns. But other than such under-the-table rewards, there are no appropriate equitizing processes.

Chairman **Stark**. Are we in any danger, if we pursue Medicare payments in the very narrow sense? There are 30 million seniors out there, and we suspect—but we do not pay a lot of attention—probably pay a very large portion of the income that hospitals collect.

If we push too hard on trying to cut Medicare costs, are we in danger of distorting what pediatricians or OBs receive, where we do not really use many of them in the Medicare process because they do not deal with Medicare beneficiaries often.

Is that something we have to worry about, or can we just go ahead and say, let's get the best price we can for Medicare, and the rest of the structure will benefit, or will not be harmed, or will adjust to that?

Dr. **Stason**. Well, certainly, Medicare commands a large share of the health-care market, as you well know, and changes in the way Medicare pays physicians are bound to have both direct and indirect effects on the way other carriers pay physicians as well.

Whether there will be an indirect effect on specialties such as pediatrics is hard to predict, but my suspicion is there will because fees are looked at in relation to each other, and if you are affecting the way internists are paid, or other office-based specialties, you indirectly will have effects on the way pediatricians are paid.

Chairman **Stark**. I have one final question. Mr. Crane testified this morning that they have one CAT scanner in England and we have thousands here. He missed the idea that England probably has 10 or less deaths, infant mortality per 1,000, whereas, Washington and Oakland have 20 per 1,000.

So we get a lot of high marks in this country for spending fabulous amounts of capital on exciting new pieces of equipment, but we somehow fail in some of the other areas to provide some pretty basic care.

Is there an American obsession with capital and equipment remote? If somebody invents a new artificial heart, do we suddenly have an urge to put one of those in everybody that will take it? So do we have to be concerned about the pressure that equipment makers and organ rebuilders put on the market, or is that not a major part of this?

Dr. **Roe**. Well, in my presentation I alluded to the four major bases for the runaway medical costs. Of course technology is one of them, and overutilization is part of technology.

It is an area that does need addressing. It is a separate subject that time does not permit dealing with here. What we think is important is that we address some of the obvious discrepancies, some of the obvious inequities, some of the gross sources of economy. Savings from the simple preliminary measures which I propose will pay for all of the stuff you heard earlier this morning. If you just had the guts to implement them, there can be no basis for criticizing them, except, of course, that somebody has to get a little less income.

Chairman **Stark**. I hate to tell you what great a political uproar that can cause, but I think you are right. Mr. Gradison.

Mr. **Gradison**. I really have no questions. I appreciate the testimony. It is extremely useful.

Chairman **Stark**. And I hope that, as with the other witnesses, we will be able to call on you both, not only call on you but encourage you to certainly send the Chair, and other members, those articles that I could read without moving my lips, that would reinforce the approach you are taking.

We do need help and you are certainly providing it for us this morning. Thanks to both of you. It is my intention to work right through. So if you do not mind, we will just proceed.

The last panel is comprised of Dr. C.S. Lewis, Jr., who is professor of medicine at the University of Oklahoma, Tulsa Medical Center; accompanied by Dr. John R. Ball, executive vice president of the American College of Physicians; Dr. Paul Ebert, director of the American College of Surgeons; and Dr. Robert Graham, the executive vice president of the American Academy of Family Physicians.

Your written prepared testimony will appear in the record in its entirety. If you would like to summarize it or expand on it, I will let you all proceed in whatever manner you are comfortable.

Dr. Lewis, you are first.

STATEMENT OF C.S. LEWIS, JR., M.D., F.A.C.P., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS, AND CLINICAL PROFESSOR OF MEDICINE, UNIVERSITY OF OKLAHOMA, TULSA MEDICAL CENTER, ACCOMPANIED BY JOHN R. BALL, M.D., J.D., EXECUTIVE VICE PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS

Dr. **Lewis**. Thank you very much.

I would like to briefly summarize or highlight the testimony presented by the American College of Physicians. Mr. Chairman and members of the subcommittee, I am Dr. C.S. Lewis, president of the American College of Physicians. I am, by way of academia, clinical professor of medicine at the University of Oklahoma, Tulsa Medical College. Basically, I am an internist in private practice of medicine in Tulsa, Okla.

With me is Dr. John R. Ball, who is the executive vice president of the American College of Physicians.

The college has been quite concerned over the need for physician payment reform for some years. It sees the recent actions by Congress to establish the Physician Payment Review Commission and to require a study of a resource-based relative value scale to be evidence of moving in the right direction and a step toward the solution of this problem.

The college feels that there are two basic concerns for this subcommittee: One, what are the principles that should be applied to any long-term reform of the physician payment system? And, secondly, what are the issues and concerns that might be applied or could be applied to a short-term set of issues or solutions to the reimbursement problem?

The college recently concluded an extensive analysis of the alternative ways in which Medicare might pay for physician services. This study was published in the January 1987 issue of the Annals of Internal Medicine. A copy of that reprint has been provided to members of the subcommittee.

This contains an analysis with three basic principles: One, an assurance of access to care, which is purposely put at number one; number two, assurance of high quality of care; and, three, a reasonable cost to ensure affordability of care.

We have found that the details of these criteria, which are listed in the testimony, are often conflicting, and that tradeoffs must be made among them.

The college's overall approach to payment system reform has been guided by several principles that we believe will lead to a clinically effective reimbursement system.

First, the goal of the payment system should be to pay appropriately for effective services.

Second, it should not perpetuate incentives for excessive, inappropriate or ineffective care.

Third, it should be based, to the extent possible, on objective, quantifiable data rather than historical anecdotes.

Fourth, it should be flexible enough to foster effective innovation and to provide for a means of modification in the face of valid changes in medical practice.

And, fifth, it should take the patient into account.

For these reasons, the college believes that a modification of the service-based reimbursement system, based on resource use, that also takes into account the effectiveness of the service and the outcome of the patient, has considerable merit.

The college has strongly supported the development of a resource-based relative value scale, and we look forward to the results of Dr. Hsaio's study.

We urge members of this subcommittee and others in Congress to avoid major revisions in Medicare physician payment policies until the results of this research are available and the consequences of changes in payment methodologies can be analyzed.

Nevertheless, we believe that certain short-term modifications can be made. It is extremely important to assure that appropriate health care services of good quality are provided safely and effectively, and to focus cost reduction efforts on eliminating those services that are unnecessary, ineffective and inappropriate.

We offer the following recommendations for immediate action, and there are three:

First, procedures reimbursed initially at an artificially high level, for reasons that have already been covered well in this testimony, should be readjusted. An example of this is coronary bypass surgery which came on as a high reimbursement item and has become more or less standardized.

Second, reimbursement for low level items may in some instances need to be readjusted. The history and physical is one, and preventive health services that lead to preventive health practices is another.

And, third, we should ensure that outmoded procedures are not performed and are not paid for.

In summary, we have outlined some short-term modifications we feel can be made to the current system without causing major disruptions. We urge the Congress to proceed cautiously in adopting further changes and to evaluate all proposals for Medicare physician payment reform against the fundamental principles and objectives of the Medicare program.

Thank you. I will be pleased to try and answer questions.

[The prepared statement follows:]

STATEMENT
of the
AMERICAN COLLEGE OF PHYSICIANS
before the
HOUSE WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

March 3, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

The American College of Physicians (ACP) is pleased to have this opportunity to appear before you today to outline our views on physician payment. I am C.S. Lewis, Jr., M.D., F.A.C.P., President of the College. I am also Clinical Professor of Medicine at the University of Oklahoma Tulsa Medical College, and I am an internist engaged in the private practice of medicine. With me is John R. Ball, M.D., J.D., F.A.C.P., the College's Executive Vice-President.

The College represents over 65,000 doctors of internal medicine, subspecialists, and physicians-in-training. Our membership includes private practitioners delivering primary health care; medical specialists in such fields as gastroenterology, endocrinology, oncology, and cardiology; medical educators; and researchers. Approximately one-third of the ACP members are Fellows of the College (FACP), a designation based upon their having met standards of scholarship and contribution to the science and practice of medicine beyond their eligibility for board certification in internal medicine.

Since its inception in 1915, the College has sought to uphold high standards in medical education, medical practice, and medical research. As payment policies have increasingly affected each of these areas, the College has become extensively involved in issues raised by physician payment policy.

Just as budget policy is linked with health policy, payment policy is linked with medical practice. We share the Subcommittee's concern that budget policy should not get in the way of good health policy, and we further believe that physician payment policy should not get in the way of good medical practice. However, having once stated these premises, their practical achievement is not as simple as we all might wish.

Over the past several years, consensus appears to have been reached--across a broad spectrum of concerned parties--that the present method of paying for physician services is in need of reform. Unfortunately, consensus has not yet been reached on what shape this needed reform should take. However, recent actions by the Congress to establish the Physician Payment Review Commission and to require the study of a resource-based Relative Value Scale appear to be moving the policy process towards the next tier of consensus. In view of the fact that research and analysis are still ongoing with regard to the future shape of the physician payment system, the questions before the Subcommittee today appear to be twofold:

- What are the principles that should be applied to any long term reform of the system of physician payment?
- What are the issues that should be addressed by any short term modification of physician payment policy?

In short, what actions can be taken now that will achieve such short-term goals as budget savings and control of the rate of increase in Part B payments, and at the same time not create roadblocks to eventual reform of the payment system? Better yet, what actions can be taken now that will be consistent with the requirements of reform and with the direction in which reform appears to be headed? Finally, what should our long range vision be? At this point, I would like to outline the College's views on approaches to be taken in both the short and long term.

Principles Applicable to Long Term System Reform

The College recently concluded an extensive analysis of the alternative ways in which Medicare might pay for physician services. Issued as a position statement of the College in November 1986, published in the *Annals of Internal Medicine* in January 1987, this statement identifies fundamental principles and objectives that we believe should apply to the Medicare program. These basic principles--assurance of access to care, assurance of high quality care, and reasonable cost to ensure affordability of care--serve as criteria by which any physician payment system may be assessed. Alternative payment methods being considered for Medicare were examined in light of these criteria, and predicted advantages and disadvantages of each were outlined. The principles and objectives identified were:

ACCESS

1. Beneficiaries should have access to needed health care services. The costs of major illness (including long-term care) or the beneficiary's share of payment should not prevent access to needed care.

2. Beneficiaries should be able to choose among physicians, a variety of health care delivery mechanisms, or both, within a pluralistic health care system.

3. Effective disease prevention and health promotion should be encouraged.

4. All health care payers should share both the responsibility and the costs of ensuring access to health care for the indigent.

QUALITY

1. There must be standards of quality and mechanisms to assure that they are maintained.

2. The payment system should not undermine the physician/patient relationship, and ought not adversely influence clinical decision-making.

3. Geographic differences in utilization of health care services should reflect actual differences in health care needs.

COST

1. Cost must be controllable and the program must be financially sound.

2. Cost-effectiveness should be encouraged, and patients should be involved in decisions that affect their health care.

3. Administrative costs should be appropriate for the efficient achievement of the program's objectives.

We found that these criteria are often conflicting and that trade-offs must be made among them. We considered restraint of cost to be an important and necessary principle of the Medicare program that should be recognized as a major constraint, but not as the principal goal. Access to health care and maintenance of standards of quality are the most important goals of Medicare.

Using the fundamental principles and objectives of the Medicare program as the basis for analysis, we examined the current fee-for-service payment methodology, as well as payment based on predetermined prices for bundles of services (similar to hospital payments based on DRGs), uniform fee schedules with and without mandatory assignment, relative value scales, and capitation arrangements. Our analysis indicated that no single method of physician payment is distinctly superior or inferior to the others. We did, however, identify expected advantages and disadvantages for each payment method, with the recognition that each may be altered significantly by individual modifications. We further found that in the absence of scientific findings derived from both short-term and long-term research studies, conclusive statements cannot be made at this time as to the specific consequences of different payment approaches. Much of this research is currently underway, as Dr. Hsiao and others have already indicated.

The College's overall approach to payment system reform has been guided by several principles that we believe will lead to a clinically-effective reimbursement system:

- o First, the goal of the payment system should be to pay appropriately for effective services.
- o Second, it should not perpetuate incentives for excessive, inappropriate, or ineffective care.
- o Third, it should be based, to the extend possible, on objective, quantifiable data, rather than on historical or normative charges, "opinions," or anecdotes.
- o Fourth, it should be flexible enough to foster effective innovation and to be modified in the face of valid changes in medical practice.
- o Fifth, it should take the patient into account.

For these reasons, the College believes that a modification of the service-based reimbursement system, based on resource use, that also takes into account the effectiveness of the service and the outcome of the patient, has considerable merit.

The College has strongly supported the development of a resource-based relative value scale. Over two years ago, we participated in development of a draft research protocol with the American College of Surgeons. Subsequent to the Health Care Financing Administration's awarding of a contract to the Harvard School of Public Health, members of the College have served on the study's consensus panels, and we look forward to the results of that study.

We urge members of this subcommittee and others in Congress to avoid major revisions in Medicare physician payment policies until the results of this research are available and the consequences of changes in payment methodologies can be analyzed.

Issues Related to Short-Term Modifications

Although it is our view that we must await the results of ongoing research studies before definitive long-term reform can be implemented, we believe that certain short-term modifications can be made. Such modifications should both provide needed budgetary savings and be consonant with the goals of overall reform. The College believes that Medicare as well as other purchasers of health care services should provide adequate and equitable payment for appropriately rendered services. It is extremely important, especially in these times of budgetary deficits and economic constraints, to assure that appropriate health care services of good quality are provided safely and effectively and to focus cost-reduction efforts on eliminating those services that are unnecessary, ineffective and inappropriate.

In addition, as we have stated on previous occasions, we believe that long-term reform of the payment system should be an objective of health policy. That objective must be kept in mind and aided, not hindered, by short-term modifications in the present system. If our common goal for Medicare (as well as for the health care enterprise in general) is to do more than merely ensure the solvency of the trust fund and to save on budget costs; if our goal is, in addition, to ensure that people in need of health care have access to some societally-agreed-upon appropriate quality of care, then we must do more than adjust how payments are made and what level those payments will be. We should focus not so much on how payment is made, but instead, on what we are all paying for. Consequently, we offer the following recommendations for immediate action:

- Procedures reimbursed initially at an artificially high level should be readjusted.

  Medical services, by and large, are reimbursed on the basis of historical charges. Where those charges were originally high, presumably in order to take into account developmental costs and the extraordinary skill necessary to perform them, high reimbursement levels may no longer be justifiable because of efficiencies in utilization and advances in medical skill.

- Service reimbursement initially at a low level should be readjusted.

  Over time, we as a society have recognized that certain services have a greater value in relation to others. Preventive health care that supports preventive health practices is one example. A pure market economy would allow such services to be priced at a level commensurate with their perceived benefit. But because of the historical charge-based nature of most third-party payment, as well as statutory and contractual limitations of reimbursement agreements, those valuable services may now be reimbursed at an artifically low level. We support a system of reimbursement based on, amoung other elements, the medical value of the service, and encourage the capability to adjust payment levels appropriately.

- We should ensure that outmoded procedures are not performed and are not paid for.

  Recent progress has been made in this area, with new efforts undertaken by the National Center for Health Services Research and Health Care Technology, as well as by Blue Cross/Blue Shield and various insurance carriers. We have found, through the College's own working relationship with Blue Cross/Blue Shield's Medical Necessity Project over the past ten years, that a request to the physician to justify procedures that the best medical advice has determined are not normally useful is a sufficient disincentive for the performance of the procedure.

One method of implementing these short-term goals is found in the efforts to better define "inherent reasonableness." The College also has supported the adoption of recent regulations to adjust Medicare payments based on determinations of inherent reasonableness, recognizing that adjustments may need to be made upward as well as downward. We hope that this approach will be used to correct some of the historical inequities that have resulted from application of the customary, prevailing and reasonable payment method. This methodology has tended to lock into place the relative pricing patterns that were in existence twenty years ago when the Medicare program was first implemented, paying highly for technological and procedural services and under-paying for non-procedural services such as physicial examinations, patient history taking, diagnostic evaluations, and patient counseling and education.

We believe there is not yet sufficient information upon which to make national policy decisions concerning geographic variations in the use of health care services. Research has shown that there are substantial variations in the use of medical and surgical procedures among Medicare populations in different geographic areas with no apparentdifferences in health. However, we do not know what utilization rates are most appropriate nor understand all the factors that might contribute to these differences. Geographic variations may be due to differences among areas in health and illness, specialty mix of physicians, physician supply and competition, health care facilities, the rate of dissemination of new technologies, customary medical practice, or numerous other factors. We urge that priority be given to epidemiological research that might help explain geographical variations so that differences in utilization reflect actual differences in health care needs.

Conclusion

In summary, we have outlined some short-term modifications that we feel can be made to the current payment system without causing major disruptions, as we all seek to determine the most desirable means of long-term reform. As the Subcommittee is well aware, there have been many major changes in physician payment policies within the past few years. The impact and consequences of most of these changes are not yet fully understood. We urge the Congress to proceed cautiously in adopting further changes and to evaluate all proposals for Medicare physician payment reform, against the fundamental principles and objectives of the Medicare program.

We appreciate this opportunity to appear before you and would be pleased to respond to any questions the Subcommittee might have.

Thank you.

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Medicare Payment for Physician Services

HEALTH AND PUBLIC POLICY COMMITTEE*, AMERICAN COLLEGE OF PHYSICIANS; Philadelphia, Pennsylvania

INCREASING ATTENTION is being given by public policymakers to alternative ways by which Medicare might pay for physician services. (1-13). Among the many approaches under consideration are modifying the existing fee-for-service system; establishing prospectively set rates for bundles of services, such as payment based on diagnosis-related groups; developing uniform fee schedules; paying fixed indemnity amounts; linking payments to relative value scales; paying on a capitation basis; or implementing a voucher system.

This position paper first reviews the historical background of Medicare payment of physicians, then identifies fundamental principles and objectives that the American College of Physicians believes should apply. These basic principles—assurance of access to care, assurance of high-quality care, and reasonable cost to ensure the affordability of care—serve as criteria by which any physician payment system may be assessed. The alternative payment approaches being considered for Medicare are evaluated in light of these criteria, and the advantages and disadvantages of each are discussed. Although the focus is on Medicare, the principles and objectives identified in this paper could have broader applications for evaluation of other medical care payment systems and other public policy options.

Background

Amendments to the Social Security Act passed in 1965 (Public Law [P.L.]89-97), which established Medicare and Medicaid, reflected a national commitment "to assure comprehensive health services of high quality for every person" (14). The Older Americans Act of 1965 (P.L. 89-73), also enacted in July 1965, declared that, among other things, elderly persons were entitled to "the best possible physical and mental health which science can make available without regard to economic status" (15). Medicare ("Health Insurance for the Aged" [Title XVIII]) was seen as a means to help elderly persons who generally could not obtain private health insurance to overcome financial barriers to access to health care. The plan, modeled on private insurance plans, consisted of 100% coverage for limited hospital services (Part A) after completion of an initial deductible amount, and separate, supplemental insurance, with coinsurance requirements, for physician services (Part B).

As originally enacted, Medicare reimbursed hospitals on a cost basis and paid for physician services based on determinations of "usual, customary, and reasonable" charges. Part A was financed from Social Security payroll taxes, and Part B, from a combination of participant premiums, general federal tax revenues, and beneficiary cost-sharing. Patients retained freedom of choice among providers, and physicians could decide on a case-by-case basis whether to accept Medicare payments (less deductibles and copayments) as payment-in-full (accept assignment) or to bill and collect from patients for full charges. Private insurers, acting as fiscal intermediaries for the federal government, administered the program. Policies established during the early years of the program (1965 to 1971) were designed to increase the accessibility of health care to elderly persons by encouraging providers to participate. Payments to physicians were intended to be comparable to, but no greater than, those paid by the general population. The statute provided specific guidance for calculating reasonable charges, but most physician charges were accepted as reasonable. Methods for determining customary and prevailing charges differed among carriers; most carriers interpreted prevailing charges to be those that were less than the 90th percentile of customary charges (16).

Governmental attempts to control rising costs during this period were generally directed at finding administrative ways to improve the organization of the program. Rapid increases in costs and consequent underfunding of the Hospital Insurance program (Part A) were addressed primarily by raising payroll taxes and increasing the earnings base to which the rates applied. This remedy has been applied repeatedly since 1966, when employers and employees each contributed 0.35% of their annual payroll earnings up to $6600. By 1986, the contribution rate had risen to 1.45%, and the wage base subject to the payroll tax of the Hospital Insurance program was $42 000 (17). In 1969, fiscal intermediaries were advised to calculate prevailing charges at 1 SD greater than the mean of customary charges (83rd percentile). In 1971,

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* This paper was developed for the Health and Public Policy Committee by the Health Care Financing Subcommittee: John M. Eisenberg, M.D., *Chairman;* Robert H. Brook, M.D.; Alan L. Gilbert, M.D.; Joyce C. Lashof, M.D.; and Ernest O. Theilen, M.D. Members of the Health and Public Policy Committee for the 1986-1987 term include Richard G. Farmer, M.D., *Chairman;* Michael A. Nevins, M.D., *Chairman,* Subcommittee on Aging; Richard B. Hornick, M.D., *Chairman,* CEA Subcommittee; Paul D. Stolley, M.D., *Chairman,* Clinical Pharmacology Subcommittee; Charles E. Lewis, M.D., *Chairman,* Health Care Delivery Subcommittee; John M. Eisenberg, M.D., *Chairman,* Health Care Financing Subcommittee; Malcolm L. Peterson, M.D., *Chairman,* Health Care Professions Subcommittee; Theodore C. Eickhoff, M.D., *Chairman,* Immunization Subcommittee; William L. Hughes, M.D., *Chairman,* State Health Policy Subcommittee; John R. Hogness, M.D., Member-at-large; Edward W. Hook, M.D., Member-at-large; and Mitchell Rabkin, M.D., Member-at-large. The principal author was Jack A. Ginsburg. This paper was adopted by the Board of Regents on 14 November 1986.

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the standard was further reduced to the 75th percentile of customary charges (18).

The Social Security Act Amendments of 1972 extended Medicare coverage to disabled persons and those with end-stage renal disease. However, this legislation also marked the beginning of an era of cost controls, with some increased emphasis on quality assurance. Limits on reasonable charges were authorized, an economic index that limited future increases in prevailing charges was created, restrictions were authorized for payment of physician services in teaching hospitals, and limits were imposed on hospital routine-operating costs. Professional standards review organizations (PSROs) were created to monitor the quality, appropriateness, and necessity of care.

Medicare rules gradually tightened between 1972 and 1981 to contain rising Medicare costs. Health maintenance organizations (HMOs) were viewed as a possible means for improving the cost-effectiveness of health care and were consequently encouraged by federal policies that gave them incentives such as exemption from health planning certificate of need requirements. However, except for a brief and temporary period of wage and price controls set forth during the Nixon Administration, Medicare costs continued to escalate. Part A costs grew from $5 billion in 1970 to $29.2 billion in 1981, and Part B costs correspondingly rose from $2.2 billion to $13.2 billion (19). These increases of nearly 500% far exceeded the 133% increase in the Consumer Price Index that occurred during the same period for all items other than medical care (17).

The 1980s marked the beginning of an era of greater federal budgetary restraints and more restrictive Medicare policies. Fears of impending insolvency for the Hospital Insurance Trust Fund (Part A) and projections of greatly expanded needs for infusions of general revenues to support the Supplemental Insurance Trust Fund (Part B) further fueled pressures on Congress to reduce Medicare costs.

Congress acted by passing the Omnibus Budget Reconciliation Acts of 1980 (P.L. 96-499) and 1981 (P.L. 97-35) and the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) (TEFRA). These acts established maximum reasonable charges that physicians could bill for laboratory services, lowered payment limits on inpatient routine operating costs, penalized hospitals for inappropriate services, increased the amount of patient deductibles, and established limits on reasonable charges for physician services provided in hospital outpatient departments. Professional standards review organizations were phased out and subsequently replaced by peer review organizations that had responsibilities for cost containment as well as utilization review. Medicare payments were also authorized to HMOs and other competitive medical plans that involved prospective payment for risk-sharing contracts.

In 1983, Congress revised Medicare's method of paying for inpatient hospital services (P.L. 98-21). The cost-based system was replaced with a prospective payment system in which hospital payment rates were predetermined based on patient discharge classification among 470 diagnosis-related groups. This legislation also directed the Secretary of the Department of Health and Human Services to prepare a report to Congress with recommendations on the "advisability and feasibility" of basing payments for physician services to hospital inpatients on a diagnosis-related-group-type system.

In 1984, Congress further responded to growing budgetary pressures by enacting the Omnibus Deficit Reduction Act (P.L. 98-369 or DEFRA), which imposed a freeze on customary and prevailing charges for physician inpatient and outpatient services and established a "participating physician" program. Physicians who chose to be participating physicians (those who would accept assignment for all Medicare patients) could increase their billed charges, but these increases would not result in higher Medicare payments during the freeze. The fee increases would, however, be recognized by Medicare in updating future charge profiles after the freeze ended. Nonparticipating physicians could continue to determine on a case-by-case basis whether or not to accept assignment, but were prohibited from raising fees to Medicare beneficiaries during the freeze.

Other changes engendered by this act included establishment of maximum limits for all clinical laboratory services whether rendered in a physician's office, independent laboratory, or hospital outpatient department, and prohibition of physicians from billing for any laboratory tests that they did not actually administer or personally supervise. In adopting this legislation Congress expressed its intention that

> . . . the burden of effectively constraining the growth of costs in the Medicare Part B program be borne by providers and physicians and not be transferred (in whole or in part) so as to become an additional burden on Part B beneficiaries in the form of increased out-of-pocket costs, reduced services, or reduced access to needed physician care.

The freeze on Medicare payments was maintained for all physicians from 1 July 1984 through 30 April 1986, and for nonparticipating physicians, through 31 December 1986.

In summary, Medicare physician payment policies appear to be evolving through a series of stages. In the first stage (1965 to 1971), the emphasis was on expanding access to health care with some efforts to obtain greater uniformity in administration. Stage 2 (1972 to 1981) consisted of various regulatory efforts to control rising expenditures through the tightening of rules, restraining of rates of increase, and revisions in health planning. In stage 3 (1981 to present) budgetary constraints are dominating policy, and legislative and regulatory actions are limiting payments for physician services.

Principles and Objectives of Physician Payment Systems

Current initiatives for Medicare cost reform offer an opportunity to reassess the nation's health care priorities and to use Medicare's payment system to help achieve national goals. If, as expected, public health care financing continues to be restricted, then choices will need to be made among priorities, and public spending will need to be targeted carefully. The following is a summary of principles and objectives that we believe should be fundamental to Medicare and that could also apply to other health insurance programs.

ACCESS

a. Beneficiaries should have access to needed health care services. The costs of major illness (including long-term care) or the beneficiary's share of payment should not prevent access to needed care.

b. Beneficiaries should be able to choose among physicians or various health care delivery mechanisms, or both, within a pluralistic health care system.

c. Effective disease prevention and health promotion should be encouraged.

d. All health care payers should share both the responsibility and the costs for ensuring access to health care for indigent persons.

QUALITY

a. There must be standards of quality and mechanisms to ensure that they are maintained.

b. The payment system should not undermine the physician-patient relationship and should not adversely influence clinical decision making.

c. Geographic differences in the use of health care services should reflect actual differences in health care needs.

COST

a. Cost must be controllable, and the program must be financially sound.

b. Cost-effectiveness should be encouraged, and patients should be involved in decisions that affect their health care.

c. Administrative costs should be appropriate for the efficient achievement of the program's objectives.

Discussion of Principles

ACCESS

a. *Beneficiaries should have access to needed health care services. The costs of major illness (including long-term care) or the beneficiary's share of payment should not prevent access to needed care.*

Access to needed health care services for aged, blind, and disabled persons has been a primary objective of the Medicare program. This objective subsumes the principles that equal access be obtainable without discrimination, that the health care system be accessible to serve the needs of all citizens, and that no Medicare beneficiary be denied needed care for lack of financial resources.

Differences in the receipt of health services should be based solely on differences in health care needs. Access to health care under Medicare should not mean that all beneficiaries should receive every treatment that is technically possible, but that each beneficiary be able to obtain whatever care is medically necessary and appropriate.

As an insurance program, Medicare should provide protection against the costs of major illness. Financial risk to individual participants should be limited, and copayment and deductible amounts should not create undue barriers that impede access to needed care. Patients and their families should not be made destitute or forced to liquidate their life savings to pay health care expenses. Consequently, Medicare coverage should include hospital and physician services as well as home health care, prescription drugs, and catastrophic expenses such as those that involve long-term health care. Beneficiaries who require continuous skilled nursing care should not have to wait until their nursing home bills reduce their financial assets to below the income eligibility levels of Medicaid before they receive public financial assistance.

b. *Beneficiaries should be able to choose among physicians or various health care delivery mechanisms, or both, within a pluralistic health care system.*

Rapport with one's physician is an essential element of effectiveness of medical care. Consequently, patients should have the ability to select a physician or health care delivery system with which they are satisfied. Several approaches to health care delivery currently exist. In the absence of evidence that any one approach is clearly superior to the others, this pluralistic system, which encourages innovation, experimentation, and personal choice, should be maintained.

c. *Effective disease prevention and health promotion should be encouraged.*

The payment system could and should be used as a mechanism to promote health and should not be concerned solely with payment for the treatment of disease. Payments should encourage the use of preventive health care initiatives such as influenza vaccinations and colorectal examinations. In addition, the payment system should include an inherent recognition of the value of periodic diagnostic assessments for continuing health care.

d. *All health care payers should share both the responsibility and the costs for ensuring access to health care for indigent persons.*

The responsibility for ensuring access to health care for those who are indigent and not covered by Medicaid or any other health insurance program must be borne by those, including the federal government, who pay for health care services. Thus, payments from Medicare, Medicaid, private insurance policies, HMOs, and self-paying patients should include the cost of caring for those who are indigent.

QUALITY

a. *There must be standards of quality and mechanisms to ensure that they are maintained.*

All patients should receive health care that is of an acceptable standard of quality. Medicare should pay only for services that are necessary, safe, and effective, and that meet appropriate standards of quality. The payment system should not encourage the use of procedures proved to have little likelihood of success that either constitute poor treatment for a specific illness or are unnecessary. Likewise, the payment system should also discourage service that does not meet appropriate standards.

Quality assurance mechanisms, including peer review, can be an effective means for ensuring the quality of care. As pressures to control health care costs intensify, it is essential that such mechanisms exist. Quality assurance programs should involve a systematic process that involves health care professionals in a coordinated system of reviewing, monitoring, and assessing care. Deficiencies in the quality and delivery of health care services, such as the provision of unnecessary or inappropriate care, should be corrected through education and administrative change, and performance should be reassessed periodically. The American College of Physicians believes that quality assurance programs should include standards, collection of reliable and valid data, peer review, and the means by which to effect behavioral change (Health and Public Policy Committee, American College of Physicians. *Quality Assurance and Utilization Review.* Position paper approved 13 September 1984).

b. *The payment system should not undermine the physician-patient relationship and should not adversely influence clinical decision making.*

Traditionally, the physician-patient relationship has been based on the premise that the fundamental responsibility of the physician is to treat patients according to the patient's best interests. In fulfilling this responsibility, physicians have earned the trust and confidence of their patients that is considered essential for good medical care. Payment mechanisms that provide financial incentives for physicians that are in conflict with the needs of patients, such as capitated health plans with profit-sharing incentives to enroll only healthy persons, could undermine this critical relationship.

Decisions to provide or withhold health care services should be tempered by ethical considerations as well as good medical judgment. Pressures to maintain hospital occupancy levels and payment incentives should not adversely influence treatment decisions.

Data are needed on the efficacy of specific medical and surgical procedures so that physicians and their patients can make well-informed treatment decisions. These data should be considered essential by Medicare for determinations of whether or not to fund new medical technologies or to continue paying for procedures no longer considered efficacious. Compensation for physician services should reflect the degree of training and experience of the physician, the amount of time and effort spent with the patient, the cost of providing the service, and the value of the service. Outcome data on probabilities of success, possible side effects, chances of recurrence, adverse risks, and mortality rates should be collected and made readily available to assist in clinical decision making.

c. *Geographic differences in the use of health care services should reflect actual differences in health care needs.*

Research has shown substantial variations in the use of medical and surgical procedures among Medicare populations in different geographic areas with no apparent differences in health (20-26). Hospitalization rates and rates for the use of medical and surgical procedures differ most in the treatment of illnesses for which there is a large degree of physician discretion. Conversely, these rates are much more uniform when applied to the treatment of conditions for which a general consensus exists concerning the effectiveness and appropriateness of care. More research is needed to explain these differences, to measure the effectiveness of medical services and their actual cost, to determine long-term effects on health status, and to understand better what rates of use are appropriate.

COST

a. *Costs must be controllable, and the program must be financially sound.*

Federal budgetary constraints and concerns about the future solvency of the Medicare trust funds have increased pressures to reduce Medicare costs. The solvency of the trust funds must be secured on a long-term basis to meet the health care needs of current and future beneficiaries.

Commitments to elderly and disabled persons should not be jeopardized by inadequate financing or by annual changes in the federal budget. Cost containment must, therefore, remain a fundamental goal of the Medicare program.

b. *Cost-effectiveness should be encouraged, and patients should be involved in decisions that affect their health care.*

The Medicare program should continue to use its market power as a major purchaser of health care services to improve the quality, accessibility, and cost-effectiveness of the nation's health care system. The payment system should not encourage the provision of care in a hospital or skilled nursing home when noninstitutional care would be more appropriate. Hospital outpatient, physician office, and home health care should be paid at levels that adequately recognize both the value of the service and actual differences in the cost of providing the service.

Payments should reflect periodic increases in costs to the provider and changes in medical practice and technology. The payment mechanism should allow adjustments in prices to reflect market conditions so that the payment system neither encourages cost escalation nor depresses prices below the point where access to care is reduced.

Patients and providers must be cost-conscious in the use of health care services. Requiring patients to bear some responsibility for the cost of services that they use is one means by which to enhance patient cost-consciousness that may also deter an excessive demand for services. Cost-sharing in the form of copayments and deductibles may be an effective means for reducing the demand for unnecessary medical services. One study of insured groups whose members were less than 65 years of age has shown that cost-sharing requirements can be effective without having adverse effects on health (27). However, cost-sharing requirements for aged, disabled, and indigent persons should not be so high as to discourage needed care and should not penalize those who are severely ill. Copayments and deductibles should be tempered by considerations of the patient's ability to pay.

Patient involvement in decisions among choices of treatment is particularly important, because these decisions depend on individual views, values, and beliefs. To make informed decisions, adequate information must be available. Patients should be informed of differences among alternative forms of treatment about expected outcomes, effectiveness, and costs. More research is needed in this area to provide better data for decision making.

The role of family and other volunteers in patient care should also be enhanced. Active involvement of the family may also serve to ensure that good quality care is obtained and may help to reduce costs by reducing the need for more costly professional or institutional care. Payment systems should encourage efforts of informal caregivers by providing needed supportive services such as home health care, homemaker services, respite care, and community health and social services.

Although the payment system should not dictate medical practice, physicians should not provide services without any consideration as to their costs. The payment system must be flexible enough to permit physician discretion in the diagnosis and treatment of illnesses in patients, but it should not encourage nor sanction clinical decisions that cannot be justified within a broad range of medically acceptable care.

Referrals and consultations must also be obtainable as needed. Payment for similar services provided by physicians of similar training and expertise should be relatively equal across the country after adjustments have been made for geographical cost differences in wages, office expenses, and other items that affect the cost of living.

Medicare policy should permit and encourage efforts to develop cost-effective alternatives that can meet the program's objectives. Thus, Medicare should sponsor rigorous scientific evaluations to test and develop alternative health care delivery and financing systems and should monitor experimental projects to ensure that beneficiaries receive appropriate services. Among the alternatives that should be explored are experiments with payment mechanisms that involve HMOs, social HMOs in which social services are provided in addition to health care, congregate living arrangements in which housing is also provided, and other capitated payment approaches such as those that involve independent practice associations. Research should also be encouraged regarding payments by episode of care; modifications to the fee-for-service system, such as the implementation of relative value scales; and the use of private insurance plans to provide coverage equivalent or superior to that provided by Medicare. Research might also focus on ways to restructure the fee-for-service system to encourage cost-effectiveness.

c. *Administrative costs should be appropriate for the efficient achievement of the program's objectives.*

The cost of administering the payment system should be kept to a minimum without compromising objectives of ensuring access to high-quality health care. Cost reporting and billing requirements should be in accord with generally accepted accounting standards but should not impose administrative burdens that discourage providers from participation.

Analysis of Alternative Methods of Physician Payment

In the sections that follow, we examine current Medicare payment policy and alternative payment approaches and evaluate each according to the fundamental principles and objectives just described.

CURRENT MEDICARE PHYSICIAN PAYMENT POLICY

Medicare has been largely successful in meeting many of the above fundamental principles concerning access and quality. Before Medicare, half of those who were 65 or older had no health insurance protection. Now nearly all elderly persons are covered by Medicare hospital insurance and over 90% (25.5 million elderly persons and 2.7 million disabled persons) are enrolled in the voluntary Supplemental Medical Insurance Program (Part B). In 1963, 68% of the elderly population saw a physician at least once a year, compared with the current 83%. Mortality rates for elderly persons, which had remained relatively constant for 12 years before the institution of Medicare, decreased rapidly and steadily after 1965 (19).

The current system has provided access to mainstream health care for elderly and disabled persons. The entire health care system has benefited from the infusion of federal financing to the Medicare and Medicaid programs. Along with these improvements in access and quality, the costs of the Medicare program have increased dramatically.

Medicare generally pays 80% of "reasonable" charges for covered physician services after the beneficiary has met a $75 annual deductible amount. Reasonable charges are the lowest of the physician's "customary" charge for a given service (that is, the median amount charged by the physician for a specific procedure in the previous year); the "prevailing" charge (that is, an upper limit set by each Medicare carrier at the 75th percentile of charges for that service among all local physicians); or the physician's actual charge. Increases in prevailing charges are further limited to rates of increase according to the national Medicare Economic Index, which is calculated using weighted averages of changes in workers' earnings and changes in physicians' office practice expenses. Customary and prevailing charge screens normally are updated annually effective 1 July, but as noted previously, since 1 July 1984, Medicare physician fee levels have been affected by fee freezes.

In 1985, more than 80% of all Medicare claims were reduced in accord with Medicare reasonable charge determinations; the average reduction was about 26%. Table 1 shows the difference between billed charges and the total amount that a physician might receive for a typical Medicare claim. The following is an evaluation of current Medicare physician payment policy based on access, quality, and cost.

Table 1. Medicare Reasonable Charge Reductions per Part B Claim for January to March 1985*

	Type of Claim†	
	Assigned	Unassigned
Average billed charge, $	122.35	128.93
Claims reduced, %	81.6	84.7
Reduction, %	26.5	25.5
Average customary, prevailing, and reasonable (CPR) reduction, $	32.48 ($122.35 × 26.5%)	32.84 ($128.93 × 25.5%)
Average approved charge, $	89.87 ($122.35 − 32.48)	96.09 ($128.93 − 32.84)
Medicare payment, $	71.90 ($89.87 × 80%)	76.87 ($96.09 × 80%)
Beneficiary coinsurance, $	17.97 ($89.87 × 20%)	19.22 ($96.09 × 20%)
Nonassigned beneficiary liability, $	0.00	32.84
Total beneficiary liability, $	17.97	52.06 ($19.22 + 32.84)
Provider receivable, $	89.87 ($71.90 + 17.97)	128.93 ($76.87 + 52.06)
Receivable, %	78.8 ($89.87/$122.35)	100.0 (128.93/$128.93)

* Data from the U.S. Health and Human Services, Health Care Financing Administration, Department of Bureau of Quality Control. Carrier Reasonable Charge and Denial Activity Report, Jan-Mar 1985. In: Office of Technology Assessment (12).

† Figures in parentheses represent equations used to derive values.

Access: Vast improvements have occurred since the establishment of Medicare.

Unrestricted beneficiary liability for copayments under Part B and lack of coverage for certain services, such as long-term care and the provision of eyeglasses, can be financial barriers to access to care, particularly for elderly persons with low incomes who do not qualify for Medicaid.

Patients have the freedom to choose among providers.

Recent changes allow beneficiaries to enroll in qualified HMOs, but not in other alternative delivery systems requiring prepayment such as Preferred Provider Organizations and privately insured plans.

Disease prevention and health promotion are not encouraged. Payments are primarily for the treatment of disease, with more generous payments for care requiring high technology and less for more time-consuming personal patient care. Copayments and deductibles may be disincentives to obtaining preventive care.

Nonmandatory assignment has allowed physicians to bill full charges to some patients and accept Medicare payments for others; thus, care for indigent patients and those with low incomes could be indirectly subsidized.

Quality: Beneficiaries receive care of the same level of quality as the general population.

Payments for in-hospital services are linked to peer review by peer review organizations, but no reviews of quality exist for services delivered outside hospitals. A lack of uniform standards and effective mechanisms for the evaluation of quality permits payments for services that are inappropriate or unnecessary.

Patient freedom to change physicians serves as a check on quality.

Traditional physician-patient relationships are maintained with the physician acting as advocate for the patient.

The payment system has a drawback, however, in that it supports geographic differences in use rates of health care service that do not appear justified.

Cost: The program has been underfunded, requiring repeated increases in payroll taxes, enrollee premiums, and federal tax revenues.

Cost containment efforts have been largely unsuccessful and the physician payment freeze is only a temporary solution.

Payment inequities exist among specialties and between established and new physicians.

The payment system encourages inpatient care as opposed to outpatient or home care.

Wide disparities exist in payments across the country that do not appear to be justified by geographic cost differences.

Acceptance of assignment and Medicare payments of 80% of reasonable charges generally results in physicians providing care at less than their usual charges.

Copayments and deductibles are the only incentives provided to encourage patients to be involved in health care decisions. Little support is provided for informal caregivers, and no support is allowed for respite care, homemaker services, or custodial care.

The enrollment of all beneficiaries under one plan and the use of fiscal intermediaries has served to keep administrative costs relatively low.

Physicians bear the burden of collecting enrollee deductibles and copayments.

Medicare has provided funding for research and demonstration projects to encourage the development of alternative methods of health care delivery.

PAYMENT BASED ON PREDETERMINED PRICES FOR BUNDLES OF SERVICES

Adoption of the prospective payment system using diagnosis-related groups as the basis for payment of inpatient hospital services has also prompted interest in payment approaches that involve prospectively set prices for predetermined bundles of physician services. Physician services in ambulatory and outpatient settings could conceivably be paid on a grouped-service basis, but attention currently is focused primarily on applying this approach only to physician services in the hospital inpatient setting. Payments could be for an all-inclusive package of services, covering all treatment incident to an initial diagnosis (as with hospital diagnosis-related groups), or could be limited to selective procedures. Packages could also be structured to involve different needs due to variations in severity of illness; different types of care, including laboratory testing, diagnostic evaluation, medical treatment, and patient counseling; the specialty of the provider or whether or not consultative assistance is required; or payment for services per episode, per visit, or per unit of time. Uniform prices would be paid for treatment regardless of the packaging and actual volume or intensity of services provided.

The success or failure of payment based on predetermined prices for bundles of services in achieving Medicare principles and objectives will differ considerably depending on the setting to which it is applied; whether acceptance of assignment is made mandatory; and to whom payment is made. The following analysis assumes that such payments would be applied only for physician services for hospital inpatients and that acceptance of assignment would be mandatory.

Access: Financial incentives would exist to minimize the provision of services.

Patients with illnesses requiring more costly services than those covered by the predetermined price might be denied care or might receive inadequate care.

Costs to previously unassigned patients and the financial risk to all beneficiaries would be reduced.

Patients would retain freedom of choice among providers who agree to accept Medicare patients.

The policy concerning referrals and to whom payment is made (for example, the hospital, medical staff, attending physician, or consulting physician) could influence specialization among physicians and hospitals (28).

Scarcely any incentive would exist to encourage health promotion or patient education.

There would be no incentive to treat indigent patients who were not receiving Medicare or Medicaid benefits.

Quality: There would be an enhanced need for standards and mechanisms to review the use of procedures and otherwise monitor physicians to ensure that patient care was not insufficient or of lower quality.

Financial disincentives to providing inappropriate or unnecessary care would be instituted; thus, overuse of services might be discouraged.

Applying this approach only to inpatient settings might result in the treatment of some patients as outpatients when they should be hospitalized, and the reverse could also apply.

If payments were made to hospitals, then physicians might tend more to be agents of the hospital as opposed to advocates for the patient, thus endangering physician-patient relationships.

Paying uniform national rates could reduce geographic disparities in the use of health care services.

Cost: Medicare might be able to use its market power to restrain or shift costs, thus enhancing the program's solvency.

The payment system could be structured so that total costs are budgeted to remain constant or be reduced.

Paying for bundles of services, as opposed to the specialty of the provider, might be a more economic way for Medicare to pay for treatment. Surgical services could be grouped more easily into uniform packages compared with medical services, because medical services can involve substantial differences in complexity of treatment and severity of illness and there are wide ranges in what is considered acceptable treatment (28, 29).

Financial incentives to provide care efficiently could keep overall costs from rising. If applied universally, this approach could create incentives to provide care in cost-effective settings and could encourage the development of more cost-effective delivery systems.

Unless beneficiary cost-sharing existed, there would be little incentive for beneficiaries and their families to be cost-conscious or involved in treatment decisions.

Physicians who provided care most efficiently could receive financial benefits, particularly those with relatively low fees and those providing services that previously would have been undervalued.

National rates could be adjusted for geographic cost differences.

Payment based on a compilation of services could be easier for the Health Care Financing Administration to administer than the existing customary, prevailing, and reasonable (CPR) payment system, especially now that payment based on diagnosis-related groups has been implemented for hospital services. Paying for a bundle of services as opposed to each one separately should decrease Medicare's administrative costs. However, there is a danger that hospitals and physicians might "game" the system by coding bills and selecting patients to maximize revenue. Physicians might also encounter cash flow problems for Medicare payments that were delayed among other providers.

UNIFORM FEE SCHEDULES WITH MANDATORY ASSIGNMENT

Medicare could simply establish its own uniform schedule of physician fees. Participating physicians could be required to accept Medicare's prices (mandatory assignment), or the fee schedule could serve as an indemnity, with the physician billing patients for total charges. The indemnity approach is analyzed separately.

Uniform fee schedules with mandatory assignment would mean that Medicare, as opposed to the physician, would determine fees. Prices could be set competitively for specific procedures and services at levels that ideally would entice sufficient numbers of physicians to participate. Many contend that the limits on increases in prevailing charges have already resulted in de-facto Medicare fee schedules.

According to this alternative, participating physicians would have to agree to accept the Medicare fees as full payment for all Medicare patients, billing patients only for deductible and copayment amounts. Medicare would make use of its market power as a major purchaser and "prudent buyer" to reduce prices. Adjustments could be made for specialty and geographic differences among providers. The following is an evaluation listing possible advantages and disadvantages to the use of uniform fee schedules with mandatory assignment.

Access: If fees were high enough to induce sufficient physician participation, then access to services might increase, especially for previously unassigned patients. The demand for services might increase as costs and financial risks associated with serious illness decrease for patients.

Patients would retain the freedom to choose among participating physicians, but there could be reduced access if fees were low and widespread nonparticipation resulted.

Legitimate differences in physician fees that reflected differences in skill or practice expenses might not be recognized; thus, some Medicare beneficiaries might be forced to obtain care only from providers who charge low fees. Access to specialist care might also be reduced.

Fee schedules could be structured to encourage health promotion and preventive health care.

Low fee schedules would not provide any incentives for the care of indigent patients who were not receiving Medicare or Medicaid benefits.

Quality: Differences in the quality of services among physicians would not be reflected in Medicare prices.

Payments could readily be limited to only procedures that were safe and effective.

Traditional physician-patient relationships would be retained.

If fee schedules were set too high, overuse of services might be encouraged.

Cost: Medicare could use its market power to reduce prices, but patient demand for services and lack of incentives for providers to limit volume could result in greater overall costs.

Incentives for "unbundling" services (billing separately) could also increase total costs.

It would be difficult to establish and update fees that reflect marketplace differences in prices.

The provision of care in cost-effective settings and the development of cost-effective delivery systems might be encouraged, but differences in overhead costs, insurance, and other practice expenses might not be recognized.

Fee schedules could be devised to create greater equity in physician payments, or they could be based on previous charge experience.

Fee schedules could be structured to encourage some types of care or to influence geographic and specialty choices of physicians. National fees could be adjusted for geographic cost differences.

Patients who previously would have had unassigned claims will have less incentive to be cost-conscious, and overuse of services could result.

Administrative costs might be lower than they are under the present system, because it would not be necessary to calculate data on customary, prevailing, and reasonable charges for each physician.

INDEMNITY METHOD

Medicare could also establish its own uniform fee schedules but without requiring mandatory assignment. The Medicare schedule of payments would indicate the amounts that Medicare would pay for specific services but would not set maximum fees. Physicians could still bill patients on a fee-for-service basis and patients would be partially reimbursed by Medicare according to a schedule of allowances. This indemnity concept applies to many workmen's compensation and commercial insurance programs. The following evaluation lists advantages and disadvantages to the use of fee schedules without mandatory assignment.

Access: If fee schedules were set too low, patients might have high out-of-pocket expenses. Financial barriers would also increase because patients would have to pay for services before receiving reimbursement. Consequently, some patients might be discouraged from seeking needed care.

Unless some form of insurance covering catastrophic health care expenses was established, or limits were set on the amounts that patients would have to pay, beneficiaries would bear the financial risks for major illness.

Freedom of choice among physicians would be maintained, beneficiaries (particularly those with low incomes) might be severely restricted in their choices.

Cost-sharing aspects of an indemnity approach might discourage patients from seeking preventive care unless generous indemnity amounts were allowed for activities designed toward health promotion and disease prevention.

Low fee schedules would not provide any incentive to care for indigent patients, but permitting higher charges to more affluent patients could subsidize such care.

Quality: The influence of Medicare on quality might decrease if the indemnified amount became a lower percentage of total charges.

Medicare could refuse to pay for ineffective or unsafe procedures.

Differences in the quality of services among physicians would not be recognized by Medicare. Beneficiaries who could afford to pay charges that were greater than the indemnified amounts might not be adversely affected, but others might be financially restricted to receiving only low-cost care.

A uniform policy involving national indemnity payments might reduce geographic differences in health care use.

Cost: Medicare could reduce its costs by setting low fee schedules.

Indemnity payment amounts could be adjusted for geographic cost differences.

Indemnity schedules based on average or historical costs might tend to perpetuate disparities in the current payment system, but schedules could also be designed to reduce such inequities.

Because financial incentives would arise for providers to increase volume and bill separately for each service, greater use of services might result.

Patients and physicians might increase their awareness of costs because they would know in advance the amounts that Medicare would pay.

Patients would have financial responsibility for differences between indemnified amounts and actual charges, including cost increases not matched by changes in indemnified payments.

Incentives for patients to shop for care might increase competition among providers and encourage alternative mechanisms for health care delivery as well.

Physicians would continue to exercise control in determining fees and would be able to bill patients for full charges. These charges would be determined primarily by competitive market prices.

The financial incentive for physicians to be cost-effective in providing health care would almost disappear.

Patients and their families would have financial interests in being cost-conscious and therefore might be more involved in decisions about patient care.

Administrative costs to Medicare of determining customary, prevailing, and reasonable charges for each physician could be eliminated.

Administrative costs to physicians might be reduced because all billings would be directly to patients, who then would be responsible for obtaining Medicare indemnification.

RELATIVE VALUE SCALES

Another variation in establishing uniform fee schedules would be for Medicare to base its fee schedules on a relative value scale. Development of such a scale involves identification and selection of criteria by which all covered medical and surgical procedures would be evaluated relative to each other. Factors that might be considered include time, complexity, resource costs, extent of medical training required, patient risk, and patient benefit. The relative importance of each selected factor would be quantified and each procedure would then be assigned a weighted value based on the extent that it typically involves each criterion. Medicare could then set one national price, or separate prices by region or area, that could be multiplied by the values on the relative value scale to produce Medicare physician fee schedules. The scale could be applied with or without requirements for mandatory acceptance of assignment, and could also be used in determining amounts to pay for packages or bundles of services. The advantages and disadvantages to using the relative value scale depend to a large extent on the criteria chosen for evaluation and the relative weights they are assigned. The following is an evaluation of some of those advantages and disadvantages.

Access: The adoption of a relative value scale for Medicare physician payments would probably have little effect on patient access to care. Access might be influenced by the way the system is applied, whether or not it is coupled with mandatory assignment, and by the level of fees.

Beneficiaries would continue to be able to choose among providers.

Referrals to specialists, particularly patient self-referrals, might be influenced depending on the relative payment for specialist services.

The scale could be used to encourage health promotion and preventive health care by giving high weights to these activities.

The use of a relative value scale only would not greatly affect the availability of services to indigent persons.

Quality: An equitable system based on this scale should have little effect on quality.

Financial disincentives could be provided to discourage inappropriate services or services of questionable quality.

An economically neutral scale based on resource costs might not encourage or discourage clinical decision making. Such a system would also have little influence in determining the setting in which services would be received.

Geographical differences in the use of health care services might be diminished.

Cost: Relative value scales could be applied to achieve cost savings or they could be budget neutral. However, lack of control over volume of services could result in net increases in costs to Medicare.

The scales could be used to encourage cost-effectiveness and could be adjusted to encourage or discourage certain activities (for example, to encourage the use of immunizations) or to help achieve social goals (such as to encourage physicians to practice in underserved areas or in specialties not widely represented).

Disparities in current payment methods might be reduced. Physicians with relatively low fees or those providing services now undervalued might receive greater income.

Justifiable geographic cost differences could be recognized.

Physicians would know in advance the amount that Medicare would pay for specific procedures.

Physician payment based on a relative value scale would have little impact on the involvement of patients and their families in decisions concerning the use of health care services.

A scale applied to a uniform fee schedule might be less complex than the present system, and costs might be reduced if calculations based on customary, prevailing, and reasonable charges were eliminated.

CAPITATION

Medicare could pay participating physicians a fixed amount per year for providing covered services to Medicare beneficiaries. Using this approach, Medicare could contract in advance with individual physicians, medical groups, hospitals, HMOs, or others to provide all or certain kinds of physician services for groups of Medicare enrollees. Various capitation arrangements are possible. Capitated contracts could be negotiated for specific numbers of covered beneficiaries, for all beneficiaries in a geographic service area, or simply for all Medicare patients who receive treatment during a specified period. Capitation could also be applied to all Medicare covered services, only to physician services for hospital inpatients, or only to physician services for outpatients. The structure of a capitation program will significantly affect its complexity, ability to control costs, and the extent of physician participation. The following is an evaluation of such a program's potential.

Access: Beneficiaries could have a designated provider or case manager who would control access to care. The danger would exist that access might be too restricted. On the other hand, access could be facilitated by a good case manager.

There would be financial incentives for providers to accept only healthy patients selectively.

Services would be available only from approved providers. Enrollees therefore might lose the freedom to self-select providers, particularly for specialty care.

Medicare beneficiaries might receive less priority or lesser attention than patients in noncapitated programs.

Medicare beneficiaries could be protected from the costs of major illness and their out-of-pocket expenses could be reduced.

Physicians would bear greater financial risks for the costs of medical care, and unless a physician belonged to a very large group, the risk might prove too great for participation.

Economic incentives to keep patients healthy could encourage preventive health care.

Although there would be no economic incentive to care for indigent patients, a capitated approach could be used to arrange for such care.

Quality: Conditions of participation could require provision of certain minimum benefits or adherence to certain standards.

Case managers usually determine what services are appropriate and screen patients so that they do not receive unnecessary care.

Professional standards and competition among providers might serve as safeguards of quality.

Financial incentives to provide the least costly care could diminish the quality of services and increase the potential for underservice.

Financial disincentives would exist for referrals and consultations.

Geographic differences in the use of health care services might more closely reflect actual differences in health care needs.

Cost: Total costs to Medicare could be predictable and controllable, and these costs would not be affected by the volume of services.

The financial solvency of the Medicare program would be improved.

Medicare could shop as a prudent buyer in the competitive marketplace. However, adjustments would need to be made for differences in patient mix based on identification of key patient characteristics, such as age or sex, that might indicate differences in severity of illness or complexity of care required. Otherwise, lowest-cost providers would have unfair competitive advantages.

The risks of cost increases and financial losses would be borne by providers and not by Medicare. Reasonable periodic adjustments in capitated payments would be necessary for the system to work. Advantages for physicians would include assurance of revenues per Medicare patient.

Efficiency and the development of cost-effective means for health care delivery would be encouraged.

Adjustments could be made to reflect geographic cost differences, or capitated amounts could be determined by competitive bidding within geographic regions.

Involvement of the patient and family in decisions about the use of services might be limited but could be influenced by cost-sharing requirements.

Administrative costs to Medicare might be reduced because there would be less need for Medicare billing and no need to maintain charge profiles or to set prices for participating providers.

VOUCHERS

Vouchers have been considered as another alternative to Medicare's current method of paying physicians. Vouchers could take the form of annual stipends or credits to be used directly by beneficiaries to pay for medical care. However, the use of vouchers would place beneficiaries at financial risk for the costs of care that exceeded amounts represented by the vouchers, might result in inadequate coverage for major medical expenses, and could create financial barriers to care for beneficiaries with low incomes. More typically, vouchers have been considered in the form that would provide each participating beneficiary with an annual stipend that could be used only for the purchase of health insurance.

Qualified insurance plans would have to offer coverage that met certain minimum standards: coverage, for example, would have to be equivalent to that provided by current Medicare health care benefits. Advantages to using these plans include the possibility that Medicare could profit from a competitive marketplace to reduce its costs and that beneficiaries might be able to shop for health insurance that better met their individual health care needs. Vouchers could be mandatory for all beneficiaries or could be made available as a voluntary option.

Medicare vouchers could be used with all of the payment approaches discussed in this paper. The effects of their use would depend primarily on the payment mechanism with which they were used and whether they were voluntary or mandatory for beneficiaries. Vouchers might work well under a capitated system of physician payment in which beneficiaries pay a fixed amount for annual health care. Under the fee-for-service or indemnity approaches, they might appeal only to the more affluent or healthier beneficiaries. Vouchers are not considered here as a separate alternative because of their overwhelming dependence on the physician payment approach with which they are coupled.

Summary

This position paper has identified 12 principles and objectives that we believe are fundamental to achieving the Medicare program's goals of assuring that elderly and disabled persons have access to health care services of an acceptable level of quality. Restraint of costs is an important and necessary principle of the program, but it should be recognized as a constraint, not a goal in itself. The American College of Physicians believes that access to health care services and maintenance of standards of quality are the most important goals of Medicare.

In this light, we examined alternative methods, currently being considered by public policy makers, by which Medicare could pay for physician services. Each approach was assessed according to the fundamental principles and objectives of access, quality, and cost that we believe should be considered in any major revision of Medicare payment policy. These criteria are often conflicting, and trade-offs must be made among them. No single method of physician payment was found to be distinctly superior or inferior to the others. Advantages and disadvantages have been predicted for each method with the recognition that each may be altered significantly by individual modifications.

Our evaluations of the different payment approaches are not intended to foretell future events, but to identify possible results that could occur. In the absence of scientific findings derived from both short-term and long-term research studies, conclusive statements cannot be made as to the specific consequences of different physician payment approaches. Consequently, although based on analysis of the best available information, our conclusions, as well as those of others, must be recognized as general. Nevertheless, we believe that considerable value exists in scrutinizing the various physician payment alternatives according to the fundamental principles and objectives of the Medicare program. We further believe that such evaluations (and reevaluations as better research data becomes available) should play an important role in shaping Medicare payment policies.

Our analysis found that the current Medicare method of physician payment under the fee-for-service system provides beneficiaries with access to health care, allows beneficiaries choices among providers, and maintains traditional physician-patient relationships. Disadvantages include unlimited cost-sharing liability for Part B services from nonparticipating physicians; inadequate protection from catastrophic medical expenses; lack of effective mechanisms to prevent provision of unnecessary and inappropriate services; ineffectiveness in controlling costs; inequities in payments among physicians; and some disincentives to the provision of cost-effective care.

Paying predetermined prices for bundles of services, such as the use of diagnosis-related groups, offers financial incentives for providing care efficiently and could reduce some disparities in physician payment. The strongest advantages to this approach are the potential for containing costs and discouraging overuse of services. Drawbacks include incentives for underservice; the potential for undermining the physician-patient relationship; lack of incentives for health promotion; and financial disincentives to care for very sick and indigent patients. Particular problems include referrals; administrative obstacles concerning to whom payments would be made and how dollars would be distributed among physicians; increased needs for quality assurance; and the potential for unduly influencing whether care is provided on an inpatient or outpatient basis.

Advantages to the use of uniform fee schedules with mandatory assignment include the retaining of patient freedom of choice among participating providers and the preservation of traditional physician-patient relationships. Costs to beneficiaries might be reduced, but costs to Medicare could increase due to greater patient demand for services and incentives for physicians to bill separately for each service. Uniform fee schedules could be devised to reduce current disparities in physician payments and could be structured to influence physicians' choices of geographic location and specialty. However, the greatest problem would be the difficulty in establishing and updating fees that accurately reflect marketplace differences. High fee schedules might result in greater access to services but could prompt their overuse as well. Low fee schedules could discourage physician participation, result in the provision of lower quality care to beneficiaries, or restrict access to only those providers who charged low fees.

The indemnity method incorporates the same features of uniform fee schedules without requiring mandatory assignment. According to the indemnity approach, however, physician charges would continue to be determined by the marketplace and the burden of financial responsibility for differences between actual charges and indemnity payments would be shifted to beneficiaries. Patient cost-consciousness might be heightened, but major problems are foreseen for patients' access to care, particularly for those with low incomes.

Development of a relative value scale would be a means of restructuring Medicare physician payment and could be used in conjunction with the current fee-for-service system or any of the other approaches. The scale could be applied to correct physician payment inequities, to encourage cost-effectiveness, and to influence physicians' practice patterns and choices among specialties and geographic locations. Application of the scale also has the potential to provide positive incentives to improve the quality and delivery of health care.

Advantages to using the capitation approach include improved cost control for Medicare, protection for beneficiaries from catastrophic expenses, encouragement of cost-effective use of services, and incentives to keep beneficiaries healthy. Disadvantages include the bearing by physicians of the financial risks for the costs of medical care, the restriction of patient access to care, and financial disincentives for referrals and consultations. In addition, potential dangers exist for underservice, selective enrollment, and distinctions in treatment of patients in capitated systems compared with other patients. Other problems include difficulty in recognizing and compensating for differences in patient mix and the need for physicians to belong to groups that are large enough to absorb the risks of participation.

Vouchers are primarily a mechanism by which payment would be made to purchase health insurance under any of the other approaches, and are not considered as a separate alternative.

Conclusions

Our analysis indicates that different problems may arise depending on which financial incentives are used to influence physician behavior. Alternative payment approaches, including the current Medicare payment method, have differing strengths and weaknesses when evaluated according to the fundamental principles and objectives of the Medicare program. Difficult choices in public policy will need to be made as to how to best achieve Medicare goals. Cost containment restraints should not be the overriding criterion dictating these choices. Each approach needs to be subjected to further research and thoroughly evaluated through testing in projects that have a rigorous research design such as randomized control trials.

In the meantime, action must be taken promptly to begin to reform the payment system so that it promotes access to high-quality, efficacious, and cost-effective comprehensive care. Utilization review and quality control are essential to maintain and improve quality, regardless of the payment mechanism. These key ingredients also should be incorporated into any payment approach for effective expenditure control.

The negative incentives and payment inequities that exist in the current fee-for-service system, with payments based on determinations of customary, prevailing, and reasonable charges, should not continue without major change. Adjustments are needed to reduce payment disparities that distort clinical decision making. Geographic differences in use of services and payment should be justified to reflect differences in the health of populations and in operating costs. Beneficiaries should not be subjected to unnecessary, ineffective, or unsafe care, and Medicare, as well as other health care payers, should pay only for services that are appropriate. Unless significant adjustments are adopted, the fee-for-service system may soon disappear.

Although extensive research efforts are needed for long-term Medicare reform, steps should be taken promptly to revise the current Medicare physician payment system. Consequently, the American College of Physicians offers the following recommendations for immediate action.

1. Attention should be given to revising the current fee-for-service system to enhance its strengths and reduce its weaknesses. Improvement and maintenance of quality should be emphasized. Payments should be closely linked to determinations of appropriateness. Accordingly, high priority should be given both to research that evaluates the effectiveness of various medical treatments, tests, and procedures, and to the rapid development of mechanisms that differentiate between appropriate and inappropriate health care services.

2. Adjustments should be made to the current Medicare payment system to correct for historical payment inequities that may induce physicians to provide technologic and procedural services as opposed to cognitive and interpersonal services such as history taking, preventive health care, or patient education and counseling.

Mechanisms also need to be developed to assess more accurately the cost of providing health care services. Payments should be reduced for certain technologic services for which costs per unit of service may decline once the procedure becomes widely used. Relative value scales could provide the means for implementing all of these adjustments; therefore, research on the development and testing of these scales should also be given high priority.

3. A pluralistic system should be maintained in which development and testing of alternative physician payment mechanisms is encouraged. Experimentation should focus on programs in which payment is based on packages or bundles of services and on various approaches that involve capitated payments. Impacts from different payment alternatives should be evaluated according to criteria similar to those we have identified before any approach is adopted nationwide.

▶ Requests for reprints should be addressed to Jack A. Ginsburg; American College of Physicians, Suite 425, 655 15th St. NW; Washington, DC 20005.

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Chairman STARK. Thank you, Dr. Lewis.
Dr. Ebert.

STATEMENT OF PAUL A. EBERT, M.D., DIRECTOR, AMERICAN COLLEGE OF SURGEONS

Dr. EBERT. Mr. Chairman and members of the subcommittee, I am Paul Ebert, director of the American College of Surgeons, and I appear before you today to highlight some of the comments that we have previously submitted.

I would state at the outset that we have not had an opportunity to review in depth the final version of the Physician Payment Review Commission that was submitted to you just yesterday. We think the Commission has done an admirable job and should be congratulated for its initial efforts.

As you are aware, the American College of Surgeons has given a great deal of study to many of the physician payment topics that are being discussed before Congress today. In March of 1984, the college convened nine meetings with representatives of the eleven major surgical specialty societies to review Medicare's payment system. I would just like to discuss several of the resulting recommendations with the subcommittee today.

The college agrees and is very concerned about apparently unreasonable geographic variations in physician's charges. Our recommendation for addressing this issue involves the adoption of a single relative value scale, preferably in each State. This scale would be established to reflect the 75th percentile of the current fees now charged in each State.

In our view, a relative value scale in each State not only would be helpful in addressing the problem of geographic fee variation, but also could be implemented in a timely fashion.

At the present time, for example, 16 States have already complied with this recommendation. We have found that variation in fees may be related many times to variations in definitions of the surgical services, even though the surgeons identified services with the same Medicare codes.

We believe that elimination of fee variations without addressing the definition problem could be extremely counterproductive. It is the college's view that defining services and procedures paid for by Medicare is a critical step in any payment reform process. Until definitions are reestablished and defined, the reasonableness of specific fees really cannot be determined.

Examples should be developed to show how codes can be collapsed for major surgical procedures paid for by Medicare. These examples then could be used as models for further study and efforts to reduce the number of codes as a means of correcting problems relating to the upcoding, so to speak, of services. The college believes that such efforts would have important cost containment benefits for the Medicare program, and obviously the high volume services and those involving large program expenditures would be the highest priority.

The current system also has been criticized many times for providing incentives to physicians to unbundle, or to submit separate charges for individual services rather than for a single global package. This incentive could be avoided if a single charge or a global fee were established for an appropriate bundle of surgical services.

The Commission's report includes an endorsement of the concept of a fee schedule to establish maximum payments for services under Medicare. However, we see no definitions or decisions that have been reached as yet on matters of the design and development of such a schedule.

One issue relates to the data base used to establish a so-called relative value scale. Is it to be current charges, current relative costs, or some other basis for establishing this value? In considering various approaches to the development of relative value scales, the college believes that the marketplace for physicians' services should be taken into account. Any approach that disregards the charges for services must substitute subjective judgments about relative values without really any clear understanding as to what those judgments might be.

We recognize, of course, that the charges for some services in areas may be excessive, and we support careful assessment of the circumstances in which such charge levels are unsatisfactory.

I think you know the truth, Mr. Chairman, is that there are great diversities in the marketplace for almost all services in the American economy, and, probably, physicians' services as well.

It should be understood that increases in physicians' charges have not been the most important reason for Medicare cost increases. The rise in volume has accounted for much of the cost increase, which is somewhat interesting because the volume of total number of surgical procedures over the past decade has remained relatively constant. Therefore, this issue should carry a high priority for study by the Commission.

The college agrees with the Commission's recommendations regarding assistants at surgery. If the definition of an assistant at surgery were more precise and the circumstances under which they are needed clarified, a cost saving would almost have to happen.

The American College of Surgeons has developed a definition of an assistant at surgery and has included this in our proposals.

We would like to thank you for having the chance to highlight our comments and would be pleased to assist in any way possible.

Thank you, Dr. Ebert.

[The prepared statement follows:]

STATEMENT

of the

AMERICAN COLLEGE OF SURGEONS

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Presented by

Paul A. Ebert, M.D., F.A.C.S.

RE: Physician Payment Reform Proposals

March 3, 1987

Mr. Chairman and Members of the Subcommittee, I am Paul A. Ebert, M.D., F.A.C.S., the Director and a Fellow of the American College of Surgeons, on whose behalf I appear before you today. The College is appreciative of this opportunity to share its views concerning possible physician payment reforms.

The American College of Surgeons, Mr. Chairman, is a voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high quality care for the surgical patient. The College provides extensive educational programs for its 48,000 Fellows and for other surgeons in the United States. In addition, we promote standards for surgical practice, disseminate medical knowledge and provide information to the general public.

We should state at the outset that we have not had an opportunity to review in-depth the final version of the report of the Physician Payment Review Commission that has been submitted to Congress.

In our view, the Commission is to be congratulated for its initial effort to examine an extremely complex topic. We believe the Commission and its staff have accomplished a great deal in developing this first report, considering the brief time available for its preparation and the difficulty of the assignment.

The College believes that any initial steps toward improvement have to be selected with care. A stable payment system is an important goal for any reform initiative. Efforts should be made to avoid, insofar as possible, unduly sharp adjustments in payment rules or levels that might disrupt the continuing availability of high quality physicians' services to patients. Initial changes made in the system should be consistent with long-term payment reform goals. Changes should not be influenced by expedient budgetary objectives.

As you know, Mr. Chairman, the American College of Surgeons has given a great deal of study to many of the physician payment topics being discussed by Congress. Beginning in March 1984, the College has convened a total of nine meetings with representatives of the 11 major surgical specialty societies to review Medicare's physician payment system. The purpose of this initiative was to ensure that the expertise of the surgical profession is considered by policymakers when changes in payment rules are discussed. As result of this effort, we have developed a set of proposals in the hope that the surgical profession may contribute in a constructive way toward making physician payment policies more rational while promoting the best practice of medical care. These proposals were approved by the College's Board of Regents in October 1986. Subsequently, the proposals were sent to each of the 11 surgical specialty societies for their review. Our comments today will focus on what we perceive to be some of the major physician payment issues, with particular attention to those which also are included in the Commission's report as part of their recommendations for near-term action.

Geographic Variations in Charges

One of the major issues addressed in the Commission's report is geographic variations in fees for Medicare services. The College also is concerned about apparently unreasonable geographic variations in physicians' charges. The College's recommendations for addressing this issue involve the adoption of a single relative value scale in each state. A statewide Medicare Relative Value Scale (MRVS) would be established to reflect the 75th percentile (the level now specified in Medicare law) of fees for service, in all localities in that state.

In our view, a relative value scale in each state not only would be helpful in addressing the problem of geographic fee variations but also could be implemented in a timely fashion. At the present time, for example, 16 states already comply with this recommendation.

Moreover, the College believes that its proposal offers a more gradual approach to correcting geographic variations, which will help to gain the cooperation and acceptance of both Medicare patients and surgeons.

Our suggestion that statewide relative value scales be used, at least initially, is based on the fact that definitions of services now paid for by Medicare are not uniform, even within a state. We have found that variations in fees may be related to variations in definitions of services even though physicians identify services with the same Medicare codes. We believe that elimination of fee variations without addressing the definition problem could be counterproductive.

Defining Payment Units

It is the College's view that defining the services and procedures paid for by Medicare is a critical step in any payment reform process. Until definitions are established, the reasonableness of some fees cannot be determined. While we believe that the Commission's report should give more emphasis to the need to develop uniform definitions, we were encouraged to learn that a subcommittee of the Commission has been appointed to address this issue in greater detail.

The College recommends in its proposal that the Secretary of Health and Human Services establish a mechanism for creating and updating a national dictionary of medical services and procedures for Medicare payment purposes. In the course of developing the dictionary, the Secretary also should consider reducing the number of codes currently used for payment purposes, relying on the advice of national organizations of specialists concerned.

Examples should be developed to show how codes can be collapsed for major surgical procedures paid for by Medicare. These examples could be used as models for further efforts to reduce the number of codes and as a means of correcting problems related to the "upcoding" of services. The College believes that such efforts would have important cost containment benefits for the Medicare program. High-volume services and those involving large program expenditures should be the first priority.

The current system also has been criticized for providing incentives to physicians to "unbundle", or to submit separate charges for individual services rather than for a single package of related services. This incentive would be avoided if a single charge or a global fee were paid for an appropriate bundle of services. The College has given careful consideration to this issue in its proposal and has defined the commencement and conclusion of a surgical bundle. We are pleased to note that the commission states in its report that the global fee paid to surgeons provides one model of a service package with which there has been extensive experience.

Fee Schedules

The Commission's report includes an endorsement of the concept of a fee schedule to establish maximum payments for services under Medicare. However, no decisions have been reached as yet on matters of the design and development of such a schedule. The College has identified a number of issues that need rational review before any such schedule could be considered.

One issue relates to the data base used to establish a relative value scale--current charges, current relative costs, or some other basis for establishing the values for services. In considering various approaches to the development of relative value scales, the College believes that the marketplace for physicians' services should be taken into account. Any approach that disregards the charges for services must substitute subjective judgments about relative values without any clear understanding as to what those judgments should be. The College also is concerned that to disregard current charges entirely may introduce some very large changes in payment levels, with possible uncertain consequences for the availability of services in some areas or the impact on program expenditures.

We recognize, of course, that the charges for some services in some areas may be excessive, and we support careful assessment of the circumstances in which such charge levels are unsatisfactory. The Congress has already given authority to the Secretary to make such determinations and to substitute--when appropriate--alternative approaches to the valuation of charges deemed to be inherently unreasonable.

Thus, the American College of Surgeons believes that careful consideration should be given to to transitional issues in moving toward a more rational payment process for Medicare. Our recommendations for moving to a statewide relative value system, for example, are based on the notion that such steps can be accomplished promptly with minimum disruption for patients or physicians. The fact is, Mr. Chairman, that there is great diversity in the marketplace for most services in the American economy, including physicians' services.

It should be understood that price increases have not been th3 most important reason for Medicare cost increases. Increases in allowed fees have been greatly constrained by the medical economic index and physician fee freezes. A rise in volume has accounted for much of the cost increase, while the volume of surgical procedures has remained relatively constant. Therefore, this issue should carry a relatively high priority for the Commission. While we believe our recommendations concerning better definitions of services and reducing the number of codes will help to alleviate the problem of increasing costs due to increasing volume of services, the dollar amounts involved are so significant that we believe the Commission should study this issue.

Assistance at Surgery

The College agrees with the Commission's recommendations regarding assistants at surgery. If the definition of an assistant at surgery were more precise and the circumstances under which they are needed were clarified, a cost saving seems likely to result. At the same time, patients would not be deprived of access to an assistant at surgery when such assistance contributes to successful treatment of the patient.

The American College of Surgeons has developed a definition of an assistant at surgery and has included the definition in our proposals. The definition establishes the circumstances under which an assistant who is a physician should be in the operating room and therefore should be reimbursed as an assistant at surgery. The College also has developed guidelines for judging the need for an assistant at surgery.

The College has approached this issue with the intent of achieving the Congressional goal of eliminating expenditures for assistants at surgery when assistance is not medically required.

Concluding Remarks

The American College of Surgeons appreciates your invitation to testify at this hearing and stands ready to provide assistance to any effort in the reform of the Medicare system for paying physicians.

Thank you.

Chairman STARK. Dr. Graham.

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. GRAHAM. Thank you very much, Mr. Chairman, I am Bob Graham, the executive vice president of the American Academy of Family Physicians. The academy is the specialty organization which represents the interests of family physicians throughout the United States, some 59,000 members. It is an association made up of individuals who are solely oriented towards and involved in the provision of primary care services in a multitude of different-size communities throughout the country.

We find that the review which the subcommittee is undertaking of the reimbursement system for physicians is extraordinarily timely. The usual, customary, and reasonable basis of reimbursement under Medicare is over 20 years old; it is antiquated, it is outdated, it provides, as you have heard, disincentives and incentives that are perverse; and it does not provide for ease of understanding on the part of either the beneficiaries or the providers.

Secondly, the undertaking that you are embarked upon is timely because of the unique resources which will be provided by the investigations of the Physician Payment Review Commission, Dr. Lee, and of the Harvard Relative Value Study, Dr. Hsiao.

The fact that these two groups are presently endeavoring to better understand and make recommendations about how the system can be revised provides you with a resource of information that would not have been available 5 years ago. We are delighted with the opportunity, as a specialty association, to work with both of these groups, but would, in particular, congratulate Dr. Lee on the timely production of a report in only 4 months of working time which is both substantive and encouraging, and Dr. Hsaio on the elucidation of a number of complex issues in physician payment.

The goals which our organization looks at in terms of an equitable or workable Medicare system could be summarized by the goals which have been set out in the Physician Payment Review Commission draft. Specifically, we look at the issues of access, quality, and equity. One of the members of the subcommittee asked earlier this morning: What is the most important goal? I believe we would say the most important goal has to be access. Yes, we are a physician organization; yes, we are concerned with equity for physicians. But the Medicare program was passed by the Congress to provide services for people, and that has to continue to be the number one goal under any physician payment reform.

We believe, as does the ACP, that there are both short- and long-term objectives that you can consider and then act upon. In the long term, in our judgment, the single most important objective is a total revision of physician payment consistent with the principles of a resource-based relative value schedule. We recognize that this may take some time. You will not have the information available to consider and act upon in 6 months, or maybe even a year; we will not have the information to comment on and interact with you in that timeframe. We know that that total revision may well take another 2 years or more. In the meantime we believe there are several specific steps which are within the purview of the committee, if you are so inclined, which could be taken in the immediate future and which could address these same principles and that could lead to revaluing some of the payment system preparatory to a consideration of a relative value schedule.

No. 1, we believe that there is no need nor rationale for specialty or geographic differentials in the prevailing charges for different types of specialists providing the same procedures. We have just concluded a 10-year legal battle with the Department of Health and Human Services, challenging this principle; the courts have found the virtue of our position; the Department of Health and Human Services has yet to implement the withdrawal of the regulation, and we may well need to deal with you in terms of assistance to assure that what we believe is a legal issue now settled is carried forward.

No. 2, the conversations which you have already heard this morning about revaluing the Medical Economic Index we think are reasonable, and that is it a timely step to take. It is particularly appropriate in terms of the concerns of family physicians because the Medical Economic Index was based on a year when the specialty of family practice essentially did not exist. That provides us some very specific problems.

Third, we believe that the authority which exists in the law now for inherent reasonableness, both to look at overvalued as well as undervalued services, should and can be used.

And the final comment about a short-term action that the committee might consider is our view of the implementation of the recently passed MAAC regulations. This causing extraordinary confusion within the physician community, as the physicians attempt to find how they can bill legally. They are not able to get that information from their carriers. That is a regulation which may need to be suspended until it can be enforced equitably.

In conclusion, I would say we appreciate having the opportunity to appear before you. We do believe that your work is timely and important. We recognize that choices are going to have to be made and that the choices may be both unpleasant and difficult. But we believe that rational alternatives will be provided on which to make those choices. We look forward to working with you.

[The prepared statement follows:]

TESTIMONY TO THE

WAYS AND MEANS HEALTH SUBCOMMITTEE

PRESENTED BY

ROBERT GRAHAM, M.D.
AMERICAN ACADEMY OF FAMILY PHYSICIANS

The American Academy of Family Physicians is pleased to have the opportunity to appear before the Subcommittee on Health to offer comments on the subject of physician payment under Medicare Part B and share the thoughts of this organization for reform of this important program.

As a starting point, the Academy believes that two goals should govern reform of physician reimbursement: access to quality health care by the Medicare population and equity in payment for physicians. Payment reform should work to enhance access by creating incentives to provide necessary medical services. Payment reform should also work to increase equity among physicians so that similar payment is made for similar services and that the relative payment for different services broadly reflects relative costs. Such reform should provide access to beneficiaries, reflecting the willingness of physicians to care for Medicare patients, and enable the beneficiaries to afford the care.

The Academy believes that reform should occur in both the short and the long term. Improvements in the customary, prevailing and reasonable (CPR) system can be made immediately, addressing such inequities as specialty and geographic differentials. In the longer term, research into a resource cost based relative value scale by the Harvard School of Public Health might assist Congress in determining alternative means of payment reform.

The American Academy of Family Physicians is particularly concerned that the Medicare payment system as it has evolved discourages the type of care that it should be encouraging--early, preventive, cost-effective, ambulatory based care, aimed at keeping the elderly person active, mobile and self sufficient. However, with its biases toward inpatient and procedurally-oriented care, the Medicare payment system creates financial disincentives for patients to seek and physicians to provide this type of care.

MEI:

A principal concern of the Academy, which was raised by the Commission in its original draft report, is the impact of the Medicare Economic Index (MEI) on family physicians. Section 224 of the Social Security Act Amendments of 1972 mandated that the prevailing charge allowed for physician services could exceed the July 1972-July 1973 prevailing charge only by an amount reflected by an index of changes in physicians operating expenses and earning levels, the Medicare Economic Index. The value of the index has been updated annually.

This provision places family physicians at a significant disadvantage relative to other physicians. The application of the index continues to be applied to the 1973 prevailing charges, exacerbating differences in relative payment patterns existing in the base year.

The specialty of family practice formally came into existence in 1969, with the result that by 1973 only 525 residency trained family physicians were in practice. The prevailing charges determined for generalist physician services in 1973 therefore reflected the charges of general practitioners, not residency trained family physicians. However, the thousands of family physicians currently treating Medicare patients have their prevailing charges based on the charges of general practitioners, since the number of family physicians in practice in 1973 was limited by the newness of the specialty.

The Academy is deeply concerned that the "adjusted" prevailing charges currently applied to specialists in family practice are inappropriately low and do not accurately reflect the level of services provided by these specialists. This is one factor which discourages the entry of more physicians into family practice and inhibits access.

The proposal included in the original PHYSPRC draft which would rebase the MEI on a more recent year does, in our opinion, have merit. In discussing this recommendation, the Commission notes that in order not to increase program costs by basing the MEI on a more recent year, some adjustment would have to be made by applying a uniform percentage discount to each prevailing charge in the new base year. The Academy is intrigued by the proposal to apply a Medicare discount to only the net income component of the MEI, rather than the practice expense component and we believe the practical effect of this proposal should be studied further. Family Physicians, have an overhead which is approximately 48% of gross income.[1] Such a proposal should also be explored as a possible incentive to increase both access and equity.

We understand from staff of the Subcommittee that the Congressional Budget Office is developing an analysis of these proposals. The results of this analysis will be of considerable interest to the AAFP and we look forward to working with you to develop realistic alternatives.

In spite of the low prevailing charges applied to family physicians relative to other types of specialists, family physicians have not increased volume to compensate for low Medicare reimbursement levels. According to a 1986 study by Juba and Sulvetta, volume increases from 1975 to 1982 contributed to the growth in Medicare spending.[2] However, the same report indicates that unlike all other specialists, which averaged a 6% annual increase in volume in services per enrollee, family physicians' comparable volume increase was 0%. According to 1983 data, Medicare approved charges per physician averaged $34,056, while the average for a family physician was $17,839.

These data help to explain that family physicians are inordinately affected by freezes and caps on actual charges as their low reimbursement levels are not compensated by increases in volume.

RVS:

Relative value schedules have the potential to provide a reasonable alternative to the current CPR system which would achieve the joint goals of equitable physician payment reform and increasing access to cost effective medical care for Medicare beneficiaries. As discussed in the PHYSPRC report there are a number of advantages in a fee schedule for payments of physician services based on a national RVS and we encourage your consideration of the Harvard resource-cost based relative value study. Relative payments for physicians' services based on amount of time and skill might help minimize distortions in the current system. There is little merit in the development of fee schedules using a charge-based RVS which would perpetuate the financial inequities which exist in the current system.

Specialty Differentials:

The Academy believes that a family physician who has the same customary charge for a service as some other specialist should be entitled to the same payment from Medicare as the other specialist and should not be paid less because the family physician is subject to a different prevailing charge. However, a Medicare regulation promulgated in 1967, two years before the birth of the specialty of family practice, has had precisely this impact.

In June 1986 the U.S. Supreme Court ruled that two lower courts did have jurisdiction in determining that the Medicare regulation allowing different prevailing fees for different types of specialists providing the same service, is in violation of the Medicare statute. We believe that as a result, the Health Care Financing Administration has a responsibility to revoke this regulation and to provide for a single prevailing fee for the same service, regardless of the specialty of the physician providing the service.

Adherence to the court decisions to eliminate this specialty differential would be an immediate Medicare payment reform of benefit to both beneficiaries and family physicians.

Establishment of a single prevailing fee for a given service is both politically and technically feasible in the near term.

Geographic Differentials:

It is not appropriate for a rural physician to be reimbursed at a lower level than an urban physician solely because he or she practices in a rural area and without regard to the fact that the fee customarily charged may be the same as the physician practicing in an urban areas. The physician in a rural area should be entitled to receive the same reimbursement as any other physician if he customarily charges the same as the other physician.

Data do not support the popular argument for the urban/rural differential that the overhead costs of supporting a practice are substantially less in rural areas. In fact, the data show that rural practice is subject to the same economic demands as urban practice. In considering various overhead items, including office payroll, office space, professional liability insurance, drugs and supplies, depreciation and equipment and continuing education, recent data[3] reported the overhead costs by geographic area as follows:

Urban	$61,810
Suburban	66,750
Rural	63,330

These figures simply do not justify continuation of the current inequity between urban and rural payment rates.

The Physician Payment Review Commission in its draft report recognized this issue and attempted to address the inequity through a proposal to provide an additional MEI adjustment to physicians practicing in Medically Underserved Areas. Whether the problem is addressed by increasing the MEI or through bonus payments to rural physicians, the methodology applied should provide for equity in payment to physicians in rural and urban areas, rather than simply provide a one-time incentive adjustment.

Inherent Reasonableness:

The AAFP supports the process of identifying and modifying reimbursement for procedures for which payment has become unreasonable. We particularly support the application of inherent reasonableness to increase Medicare payments for some services which are undervalued as well as reduce payments for overpriced services. The Inherently Reasonable authority can be used to make immediate adjustments in Medicare payments while more comprehensive physician payment reform is being developed.

Participation:

It is no coincidence that the specialists with the highest incomes tend to have the highest "participation rates." Figures released by HCFA indicate that 27.9 percent of all physicians treating Medicare patients have signed agreements to become participating physicians. The participation rate for family physicians is 27.1%, which is substantially less than for other specialists such as nephrologists, which have a rate of 46.2%.

Data published in February 1986 note that from 1980 to 1985 the inflation rate as measured by the CPI rose 37%. During the same time frame, the median annual net income of family physicians rose only 13% while that of other specialists increased significantly, for example 19% for internists and 37% for cardiologists.4

Efforts to address payment equity for physicians will enhance access to care by encouraging physicians to become "participating physicians."

MAAC Program:

Last year in the Omnibus Budget Reconciliation Act Congress enacted a provision to limit physicians' maximum allowable charges--known as the MAAC program. Since the inception of the program, the Academy has been contacted by many family physicians who have been advised by their Medicare carriers of their MAAC levels, only to discover that the levels have been calculated inaccurately. Physicians are confused as to what they may appropriately charge for Medicare services. Review and correction of the multiple problems with the MAAC program will be a long and complicated process. Because of the difficulties already experienced with the MAAC program, we would urge

Congress to evaluate the administrative feasibility of the various Medicare proposals under consideration to avoid creating another program that is difficult, if not impossible, to implement correctly

Summary:

The current Medicare physician payment system discourages early, ambulatory, preventive, cost-effective care while encouraging procedurally-oriented, expensive care. The AAFP is concerned that such patterns in reimbursement have diminished the ability of the elderly to receive primary care services. We urge Congress to consider not only how Medicare pays for services, but also what it pays for and whether the present distribution of Medicare dollars is appropriate given the goals of the program. Efforts by the Congress to restrain costs in the Medicare program should be crafted carefully to enhance the goals of access and equity. A short term cost savings achieved to meet budget targets must be evaluated in view of its long term policy implications for the health care of the American public.

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1. Medical Economics. February 3, 1986.

2. Juba and Sulvetta. 1986 "Trends in Medicare Payment for Physician Servies." Medicare Physician Payment Reform; Issues and Options.

3. Medical Economics. November 1985.

4. Medical Economics. February 3, 1986.

Chairman **Stark**. Thank you very much. I suppose that it does not take a lot of understanding to figure that somewhere between Dr. Lewis and Dr. Graham, Dr. Ebert, your members lose some. You are at the higher end of the scale, and the internists, I guess, and the family physicians are somewhat lower. If we start adjusting, some may come out of your pocket. Some of the questions here may tend to pick on you a little bit, but I do not mean it in that sense. But we have heard today a lot of testimony about high-priced procedures that I suspect that maybe family physicians do some of that. What you are saying is both, if we cut the procedures, the payment for procedures that a family physician might perform—are they surgeons, too?

Dr. **Graham**. There are still a few isolated areas of the country where family physicians are actively involved in surgery. Most commonly, where there is an adequate supply of surgeons, family physicians no longer provide that as a primary surgeon.

Chairman **Stark**. The major question that I have is with respect to your testimony about the 75th percentile. And it is my inclination to say—and it is an idea that Mr. Gradison has suggested often—why are we paying 75 percent? What if went into the market place for and bargained for services—at the 25th percentile? Is that an area where we could negotiate? Is there any impact on quality or access, or is that just a matter of you and me bargaining—I say 25 and you say 75, and then it would not take us long to get to 50. Do you want to comment on that? I know historically it is there, but is there any other reason than you got a good deal historically that we can not move on that without impacting on the overall practice of medicine?

Dr. **Ebert**. I really don't know. We picked the 75 because that is what you said we should pick, and we felt that much of the problem is relating to what the actual charge is, and if Medicare would balance out the high and low parts, so to speak, of all the medical profession. And I must say my comments really relate almost entirely to surgical procedures. We picked the 75 percent predominantly because that is what the Medicare law stated. I mean, if you were to come by tomorrow——

Chairman **Stark**. It is three times better than 25, I can figure that one out.

Dr. **Ebert**. I think that particular 75-percent number would apply to all of us across the board. I mean, it was not just the surgeons.

Chairman **Stark**. I know that. The other question that I would like to direct to you, Dr. Ebert, is that you are recommending a charge-based value scale, and Dr. Lee and Dr. Hsaio are talking about a different basis, and they feel that the charge-based would leave distortions in the market. Do you want to comment at all on that?

Dr. **Ebert**. Well, Mr. Chairman, I think the comments would really relate to the fact that we really have no experience with a resource-based profile.

Chairman **Stark**. I do not think anybody does.

Dr. **Ebert**. And the American College of Surgeons felt that there were a lot of arbitrary or subjective numbers that would have to be put into such a factor. I could agree to all the factors that go into it, but if you told me what the multiplier was to be at each point, I guess I would be more able to say whether it was a valuable or invaluable scale. We think there is a tremendous historical market place history—maybe it is incorrect, maybe it needs adjustments. But at least it is there, it could be reasonably implemented.

I think the other point that we were concerned about had to do with whether you pick one nationwide relative value scale or whether you did it on a state basis. Right now there is something like 220 or 230 RVS scales around, and since there is such widespread geographic variation, by taking it in an implemental stage—50 States at a time or 50 districts—I think you would have less unhappiness among the entire profession, because some States would be under average and would be raised, and others would be reduced. And we are as concerned about access and for beneficiaries as anyone else. But, on the other hand, if we took one number across the country, I think we would have a difficult time in one step.

Chairman STARK. Let me follow up on that, if I may, and ask you to comment on this, because I have said it often in what I hope is a humorous vein, but still unable to understand it any further. Let us assume for a minute—and I am not sure this is the procedure, but we heard about gall bladders before, and we have also heard testimony that there is some real disparity in charges for basically the same procedure. Let us assume for a minute that it is gall bladders, and that you can have it done for $1,000 in Atlanta and $2,000 in San Francisco. And as long, then, as the roundtrip airfare is less than a thousand dollars, why should not we just say it is a thousand dollars plus airfare? I know that sounds a little harsh. And then let your members decide why they are getting twice as much in San Francisco as they are in Atlanta—or actually the case may be that I have even heard is between New Haven and Boston, where Mr. Gradison has experience knowing that both cities are uncomfortable to live in. So there is no tilt. [Laughter.]

At some point, what would be wrong with setting this price, because we know it can get done in a community, taking into account wage base and everything else, and let you decide how you are going to react to that? What are the dangers you see in that kind of a strictly empirical approach to straightening out some of these problems?

Dr. EBERT. Well, if you will, let me just answer by posing another question to that before I give you an answer. I believe that one of the problems, as we state in our testimony, is that these RVS packages are totally different around the country, and for $2,000 in San Francisco, let us say, maybe you got preoperative care, postoperative care, 6 months followup, and whatever, within a surgical package, and in another situation, although on paper the cholecystectomy or gall bladder operation costs one-half as much, if other bills were submitted for other types of followup care, we do not know whether the packages are the same. So I would be cautious only in that regard.

And to answer the question directly, I would only worry that if you made such a large implemental change across where there are such wide variations in fees, if the total average fees, let us say, in San Francisco were twice as much in Atlanta, then I think you run the risk of denying access and lowering services in the Bay Area, for instance. If you were, on the other hand, to find that there was not that much discrepancy and there were very high fees in one area among a small percent—and I still believe that 10 or 15 percent of surgical services that are overpriced get us 99 percent of our criticism from everyone—and if we eliminated the top 10 percent or the top 15 percent and came up with another number, I think we would all be very happy with that.

Chairman **Stark**. Just one more question, and that is to Dr. Graham. The committee, I think, HCFA and myself have tried to encourage participation, and I have tried to make it plain that the reason for encouraging participation is basically not punitive in terms of the medical profession, but in fact to make it simpler and less confusing to the beneficiary. And some groups have flirted with the idea of mandatory assignment or 100-percent participation, and what they have suggested is, yes, but can we really trust you. In other words, if you did not break us and ruin our practice and make us take a huge cut in income, it is kind of attractive.

I guess my question to you is, for a family practitioner, is there some other impediment? In other words, is the question whether we could sign up the members of your organization under participation, strictly one of price, or are there some areas where we would have to—in other words, could I find a price where I could get your group to say, yes, we would like to be a hundred-percent participating, or are there other nonmonetary considerations in there that I am missing?

Dr. **Graham**. I think the issues for family physicians are primarily ones of monetary fairness. That is not to say that a given physician or group in a particular area might have some other concerns. But as I have talked with our members, as I have discussed this issue with our board, by far and away the greatest difficulty that we are wrestling with is the issue that we view family physician services under the present Medicare reimbursement system as being disproportionately undervalued. That provides us with a lot of difficulty in going to our members and saying "do the right thing, become a participating physician," because our members come back and say have you seen the prevailings? You know, there is page after page in this HCFA document where the prevailings for a generalist are 50 to 100 percent different than the prevailings for a specialist—and, of course, in some States our members fall into one batch and in some they fall into another.

So, you know, given the fact that I said our primary goal in looking at revision of the Medicare payment system is, first, how are the beneficiaries treated, what does this do about access? For us today, under the present reimbursement system, to try to mandate participation I believe would be a failure with our group.

In a future time, when we were able to look those members in the eye and say we believe that family physicians are being paid fairly, absolutely and relative to the other specialists in medicine, for their services, I think you would find our organization willing to work with you to try to accomplish that

As a matter of fact, today the vast majority of family physicians participate on assignment with a number of their patients. These

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decisions are, however, based upon their knowledge of the patients and their means, electing in some cases to balance bill.

Chairman STARK. I can not resist this last question, Dr. Graham. I guess I have to challenge you there. But I have asked this of every physician in private practice that I know, both among my acquaintances and those who have come before the committee, and I have yet really to find a physician who has in his office supply cabinet a financial form for a patient to fill out, or would really have the expertise to determine once the patient filled out a balance sheet and income statement what they could afford to pay. In other words, I am sure they could do the best possible job in diagnosing physiological disorders, but I just challenge whether a doctor really can make a decision on what a patient can afford to pay, based on their training and based on their staffing. I think that is what every doctor thinks they do, but I just do not believe they do that with any kind of scientific or empirical judgment.

And I could not let that one slip by. If you know of a procedure that they use differently, I would be willing to stand corrected. But I think that is more in the doctor's imagination that it is in practice.

Dr. GRAHAM. If I could respond briefly—and I recognize that we may just have kind of a conceptual difference—by and large our members are community-based, as you can understand; that is the nature of primary care practice. I do not know what types of physicians you have come in contact with as you built your data base. When I see a difference of 27 percent family physicians as participating physicians—and some of our data would suggest that upward of 70 percent accept assignment on some basis—I know there is something going on in their minds; they are making decisions. And I believe in the vast majority of our members' cases they do know their patients; that is the essence of family practice is a continuity-of-care relationship over time; it is not one episode here, another episode 10 years later—they really do know their patients and they struggle with their patients to provide that balance of access and still being able to run a medical care practice.

So I am not sure I can convince you with anecdote, but I am comfortable in saying I believe there are those members out there.

Chairman STARK. I would be more comfortable accepting that from you, particularly in smaller communities where there is a long-term and close personal relationship with an entire family, as family practice would indicate. But nonetheless I still would challenge—just as they would certainly be able to challenge my ability, as a former banker, to diagnose flu from AIDS or acute appendicitis; I would reserve the right to say I will bet you that they are misled often on their patients' ability to pay.

Be that as it may, I do recognize that—and I rather suspect, for instance, that your practices are not so much among the high-income group as the moderate or lower income groups, where it would be essential, it seems to me, to have more participation.

Dr. GRAHAM. I do not want to prolong this unnecessarily: I will accept your implicit wager; I will work out with your staff the next time that you are back home in the district, we will identify two or our members who will have an hour of time to sit down with you and talk about how they make those decisions in their practice.

Chairman **Stark**. OK, you are on. Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman. Dr. Ebert, Dr. Hsaio earlier said that your organization had chosen not to participate in their study. Is that correct? And, if so, why?

Dr. **Ebert**. Well, I think the decision was made 2 years ago, and was made with considerable amount of discussion among the colleagues. And mainly for the two points that I made before, that we felt that it was too subjective, it was to be a limited number of procedures, so it was not going to encompass the entire spectrum of surgical operations, and we did not feel that we really knew how to reply to it, and that we were more interested in developing our own proposal than trying to reform the system without going through a total revamping and rescheduling within surgery. We have had more experience in surgery with RVS scales over the years in some States than other physicians, so I guess we felt that our chances of sitting down and arguing out what a hip replacement was worth in comparison to a gall bladder—there are still those subjective value points you have to put on: length of training, amount of time, and so forth. And there is a lot of variation between cases. So it is very hard I think to get a standard approach.

So we just decided we would stay with our other proposal.

Mr. **Gradison**. While you are not participating, do you have any impressions as to whether that study is taking into account the concerns which you have mentioned, not necessarily whether they are going to come up with an answer that you would support? Would you have any comments on the process which they are following? Will it, without your participation, result in the point of view of your members not being considered adequately?

Dr. **Ebert**. I think since the study is sponsored predominantly by the AMA, and there are numerous surgical members of the AMA, I do not believe that Dr. Hsaio has any difficulty getting surgical input into his information, I mean, into the data bank that he is going to draw his conclusions—so I do not know that our participating or not would have any real influence on the study, per se. I imagine it would not.

Mr. **Gradison**. We are glad you are participating this afternoon. Thank you very much, Mr. Chairman. Thank you, doctor.

Mr. **Donnelly**. Thank you, Mr. Chairman. Let me just ask Dr. Ebert and Dr. Lewis a question about assignment.

We had an opportunity to hear Dr. Graham respond to the chairman. What would it take—if we revamped the physicians' payment system—what would it take to have your organizations or your membership accept mandatory assignment?

Is the problem a financial one, or is it a philosophic one?

Dr. **Lewis**. To accept?

Mr. **Donnelly**. Mandatory assignment. Universal participation.

Dr. **Lewis**. I shall be glad to take a shot at that.

Mr. **Donnelly**. In 49 States—we have it in one.

Dr. **Lewis**. Sir?

Mr. **Donnelly**. We already have it in one State. Very progressive State.

Dr. **Lewis**. I realize that. One of our founders——

Mr. **Donnelly**. One of the Original Thirteen.

Chairman STARK. Answer him quickly, doctor—he will go on all morning.

Dr. LEWIS. I think the American College of Physicians' members would be very uneasy about mandatory assignment universally in this country.

The main reasons have to do, I think, with the fact that that is a limiting factor on choice for the patient and choice for the physician, to the extent that, under the present mechanism, you can accept assignment for all those cases that it is appropriate; and there are a lot of people that are. And I agree, we may not have very scientific ways of identifying who that is, but you know when somebody comes in in a nun's habit, it is easy to tell——

Mr. GRADISON. I shall remember that. I will look a little silly, but it will probably save me a bit of money.

Dr. LEWIS. Nevertheless, I think identifying people who need that sort of protection is not all that difficult. I think there is a significant group not in the Medicare age group, particularly, that need even more help than that. For a physician to be able to balance out free care, limited payment care or assignment care, and balance-billing type patients, then that point tends to even itself out.

I am really concerned that the major question, and major problem, in our country is really not a question of assignment or nonassignment. It is a question of access to care. That is what the College of Physicians put as our first priority. There are a lot of people, and particularly young mothers and infants, that are not receiving adequate care in this country today. I think that is our major problem.

I realize that we have to settle this problem of physician payment, but I think that in order to provide access for all people, it will end up better if we leave the assignment situation the way it is, where you do have a choice. I think it is used well that way.

Mr. GRADISON. What you are saying, in effect, is that you still want to be able to factor in people's ability to pay. Would that paraphrase your answer?

Dr. LEWIS. I think that produces the best result.

Mr. GRADISON. Doctor.

Dr. EBERT. I think more surgeons have accepted assignment than other physicians, if you go through the total percentages, listed at least by the medical directories.

But I think in general we would worry that mandatory assignment, even in the one State that does have it, has a rather severe penalty tied to it at the moment—taking away licensure—so that would tell me that it must not be terribly warmly received, or that those implementing it must have grave concern over the fact that it will be utilized.

I think that a better payment reform system, where either by rapidity of response, a higher percent return on reasonable charges, is more apt to have physicians participate than having the mallethead held over their head as it is in that one particular State.

Mr. GRADISON. The potential of losing your license, I would suspect, is a motivating——

Dr. EBERT. It has an incentive value, yes.

Mr. GRADISON. Thank you, Mr. Ebert.

Chairman **Stark**. Can I ask just one final question, and then you all can go to lunch? People are in a profession because they do want to serve. I think that is a given, and I think it is probably perceived by the public and by us, and certainly you all.

How do you wash these kinds of inconsistencies? Here is what I see that is wrong with the system. Robert Wood Johnson Foundation says that a couple of years ago, less than 6 million people in the country did not get medical care; about 1 million because they actually could not afford it; and 4 or 5 million because they thought they could not afford it. So they had the perception they would not want to spend the money. That is not very many.

But then you go to communities like one in my district, Oakland, where we really have 20 in 1,000, mortality rate. That is obscene. We have the same problem here in the District of Columbia. You can put up a whole host of social reasons, but I have not noticed the people I know in the physicians' community writing me letters saying, we have to do something about this.

We are cutting the Federal aid for the free clinic in my district and when I was elected in 1972 we had 20 in 1,000 infant mortality, and I would not be surprised if it has not changed one whit.

So we have yakked a lot about it, as have the politicians, providers, and the community hospitals. We have not made any progress. I am not suggesting just the adage, just because we are the richest nation in the world—but we are not poor, certainly, in medical and technical resources.

I guess what I am saying is, is it not time that we knew a little bit more exactly how many physicians are providing extra care, how high you have to charge to compensate for the uncompensated care? Because obviously the system—nobody's getting anything free.

It may be just that I am paying more real estate taxes in Oakland because the county hospital is providing that, and they are contracting for physicians on a salary to provide it; or maybe there is a whole host of things we do not know. But that is really why I think we have got to follow up on what Dr. Lee is trying to do, and what Dr. Hsiao is trying to do. We do not know.

We know that there is a social ill out there, and we know that the present system, whether it is public financing, whether it is charitable contributions by the profession, or whether it is the Federal Government trying to throw money at the problem, it isn't being solved.

Therefore, maybe we just ought to get more information and begin to try some of these experimental things, as they have in Massachusetts. I do not know what is going to happen if you have communities—if you have South Boston, for instance, if you segregate problems in various communities that are close to Lawrence. But somehow there are those problems, and I think they cost us more in the long run.

I am convinced that prenatal care and decent obstetrical care in the first year of pediatrics would save us so much more money long-range. I do not get any budget credit for that, because I can not prove it. I can not come out with any empirical data. I hope that you all will help us in that.

In some cases what we are going to have to do is question, not your good intentions, but whether we actually keep track of how much free service is given, or how much judgment is made in billing, or how much is really done by the office manager. I do not know that. I hope you will help us find it out.

Because I think we will come out with a fairer system; and if we could, as I say—I do not mind the tension. I will bargain with you for that removal of my gallbladder without having to put on a nun's habit, but then let us bargain together, because if we do it together, we will get one where you will be happy participating, I will save the taxpayers some money, and we maybe will have the system open. That's what I think we can accomplish.

Dr. Lewis. May I respond to that? And I would like to ask Dr. Ball to assist.

The American College of Physicians is concerned about this, as I tried to point out that access is still the most important problem in our country, as far as health care is concerned, in our opinion.

And we have a mechanism for monitoring just how much needed care is not being given, and plan to spend a reasonable amount of time and effort and resources at the college on continuing that monitoring process.

Because I think, together, we do need to work this out. And I am going to send you a copy of my January President's column on what we feel about this sort of care. [The document has been retained in the committee files.]

Chairman Stark. Be kind to me in your words——

Dr. Lewis. I would like to ask Dr. Ball to——

Chairman Stark. Dr. Ball, go ahead.

Dr. Ball. Just one comment. I think you had put your finger on the issue a little bit earlier when you said that Americans have a love affair with technology. They do not have a love affair with well-baby care, as measured in economic value. We certainly need to develop better technologies to take care of folks, but at the same time, we overvalue that in how we pay, and we undervalue the well-baby care, the preventive kind of care, the thinking that physicians do in deciding how to manage the patient. I think in approaching use long-term system reform that this committee is going to do, that you ought to take a look at the way in which you can revalue care on the basis of the value that it does have, not on the basis of what the historical prices have been. You can do some of that in the short term and both Dr. Graham and we have talked about it, as well as Dr. Hsiao. That will lead, I think, over the long term, to better health care.

Dr. Lewis. Thank you.

Chairman Stark. Thank you.

Dr. Graham. May I make a comment, too?

Chairman Stark. Please, do.

Dr. Graham. I think this is an important issue. I know you do not want to start another hearing. I would urge the subcommittee, in its consideration of physician payment reform, not to believe that the issues of access to service or medical indigence can be solved simply by paying a different rate.

I do not believe the answer to that issue is more free care. I think the answer to that issue is the medical profession being able to work with public and other institutions to find a way that every American has access to care under some plan or another.

If the Robert Wood Johnson Foundation thought it was 6 million medically indigent in 1981, the figures now are somewhere betweem 30 to 50 million Americans who, during some time of the year are without medical care insurance. That is the issue that I believe we need to pursue together.

Chairman STARK. But those people—I was just making a point—those people still may be able to get care, even though they do not have insurance. It may be at the county hospital, maybe what you might call in some other areas, the poor farm. We do not let them bleed to death on the streets, generally.

Dr. GRAHAM. Only slowly. If you have a head injury in Oakland, I suspect the care that you get is extraordinarily good. If you have an unintended pregnancy, it is probably not so good. We let the slow disasters take place, not the catastrophic ones.

Chairman STARK. I will accept that.

I want to thank the panel very much. I look forward to working with you over the year ahead. Thanks a lot. The committee is adjourned.

[Whereupon, at 1:25 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Mr. Chairman and members of the Committee, I am Reginald Cooper, M.D., President of the American Academy of Orthopaedic Surgeons and Chairman of the Department of Orthopaedic Surgery at the University of Iowa Medical School.

We appreciate the opportunity to present this written statement to the Subcommittee on Health, as part of its March 3, 1987 hearing on physician payment under Medicare Part B.

The Academy is comprised of over 11,000 fellows, all of whom are Board Certified in the specialty of orthopaedic surgery. A substantial part of our practice is devoted to caring for the myriad of musculoskeletal problems which afflict our senior citizens. As advocates for our patients, we believe the elderly have a right to timely, appropriate, and cost-effective care.

The fellows of the Academy are aware that costs have risen rapidly under the current customary, prevailing and reasonable charge method of reimbursement. As such, the Academy, through its committee structure and staff, continues to examine ways to reform physician reimbursement under the Medicare program that will assure the elderly patient access to quality care.

We are concerned, however, that some of the proposals for reform may overlook the medical needs of the patient and, instead, concentrate only on the "bottom line." While saving money or maximizing the investment of Medicare dollars is important, it should not become a barrier to quality medical care.

On behaf of the fellows, I would like to address two issues in this statement:

First, we are concerned about the current proposal to institute an MD-DRG payment for physicians, in particular radiologists, anesthesiologists, and pathologists. Specifically, we see the following problems with such a scheme:

The proposed system diminishes the physician's traditional role as patient advocate.

Patient care decisions could be determined by financial considerations rather than quality of care considerations.

The hospital DRG system which currently underpays for intensive and complex service could be compounded, resulting in additional disincentives to handle these types of cases.

The discrepancies in payment to inner city and rural hospital would be increased. Financially strained institutions would have incentive to use the added funding for the MD portion of the DRG payment to alleviate deficits. This could reduce payment levels to physicians and could reduce the attractiveness of these institutions as practice sites.

Additional personnel would be needed by physicians and hospitals to handle the negotiations and administration; thereby increasing overhead costs.

The process could introduce new tensions between physicians and hospitals which are likely to be time consuming and have negative effects on the quality of patient care.

Recent studies on physician reimbursement by several government agencies have pointed out the lack of experience with physician DRGs and speculated that many problems could arise if such a system were implemented. In April of 1986, the Congressional Budget Office stated in a report that "Implementation would not be feasible until a case-classification suitable for physician services had been developed." Moreover, the report went on to say, ". . . that physicians might not serve as effectively as advocates for their patients. Consequently, the need for Medicare to monitor the quality of care provided would increase." The Academy agrees with this statement and, moreover, it is our opinion that the proposed MD–DRG system will move economics to the forefront and relegate quality to the background.

It appears to us that there are many unanswered questions about how such a program would be administered and what it will do to overall quality and access to care. For example, what is an episode of care? Will the system allow for variations in severity? How will payment levels be determined, given the geographic variation in cost of resources? How will "package" content be defined? How can the payment arrangements between hospitals and physicians be set up in a way that will not adversely affect patient care?

Mr. Chairman and members of the Committee, we urge you not to proceed in a precipitous manner by adopting the MD–DRG as a physician payment reform.

The second issue I wish to address is the adoption of a relative value scale (RVS) as the basis for setting physician payments under Medicare. While the Academy believes that a properly constructed relative value scale has the potential of moving towards a more rational payment process for physicians under Medicare, we are concerned that Congress and the Administration may be locking in on a specific approach, namely the Hsiao-resource based RVS, at the exclusion of other methodologies. We urge this Committee to examine other data bases in order to assure itself that a proper RVS is constructed to protect access to quality patient care.

Our specific concerns with the resource based RVS is that it does not adequately consider such factors as complexity, severity, geographic practice cost differential, and the marketplace for physician services. We believe these factors must be present in the formulation of a proper relative value scale. Their absence could ultimately be disruptive for patients and physicians.

At this point, Mr. Chairman, I would like to indicate that the Academy has formally adopted a position statement on physician reimbursement reform and has identified the following principles which must be considered as part of any reform:

(1) Any payment system must have as its first priority the patient's medical needs, with economics having a secondary role.

(2) The national debate on health care reimbursement must include discussion of the problems and needs of the medically indigent.

(3) No single approach will satisfy the needs of all citizens. It is necessary for a variety of reimbursement schemes to be available, at least until such time as one has proven so far superior that universal adoption is indicated.

(4) Any system should encourage development and introduction of technological advances which will contribute to high quality patient care.

(5) A system which makes access to specialty care cumbersome or costly may prove to be adverse to quality health care.

(6) A system which rewards withholding of care must be avoided.

(7) Excessive fees or excessive care are not in the public's best interest. The medical community, individually and collectively, has a responsibility to identify opportunities and methods to reduce excessive fees and care and promote cost-effective care.

(8) The public must be thoroughly informed of health care payment and delivery options available to them, along with their advantages and disadvantages, including quality of care implications.

We urge the Committee to take these principles into consideration as it explores ways to modify physician reimbursement.

We fully appreciate the difficult task confronting the Congress, namely reducing the budget deficit, while maintaining a sound Medicare program for our senior citizens. As such, we wish to point out that we, through our committees and staff, are prepared to work with the Congress to identify a system which provides the elderly with timely, appropriate, and cost-effective care, while preserving the physician's role as the patient's advocate.

Thank you for this opportunity to share our views and we look forward to working with you in the future.

STATEMENT

OF THE

AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons (AARP) welcomes the opportunity to submit this statement concerning physician payment reform under Medicare for the record. AARP represents more than 24 million Americans over the age of 50.

AARP shares with Congress concern about costs associated with physician services. These rose 18% a year between 1980 and 1984. Indeed, Part B is the fastest growing component of domestic federal programs; annual growth is projected at 14% through 1988. Moreover, this growth comes despite a Congressional freeze on physician fees from July 1, 1984 to December 31, 1986.

We believe that the current fee for service reimbursement system encourages physicians to set ever higher prices and to deliver more services than may be medically necessary. All of the evidence points to these two factors as key contributors to rising Part B costs. There is no evidence that patient demand accounts for higher costs. Furthermore, the current payment method exposes beneficiaries to high unpredictable out of pocket costs and disproportionate liability for physician services. In fact, beneficiaries are directly liable for 60% of physician charges.

Medical liability for beneficiaries arises from many sources. For Part B covered services, beneficiaries are responsible for a premium; an annual deductible; a 20% co-payment; and any fees above Medicare's reasonable charge for covered services. Furthermore, patients are wholly responsible for the cost of many types of uncovered goods and services recommended by physicians as a direct result of a physician visit. The physician's practice style and professional judgement directly influence utilization of these uncovered goods and services. A more detailed explanation of these sources of liability follows.

To begin, it is important to recognize that out-of-pocket payments by older Americans constitute the second largest source of payment for the total cost of all the health expenditures on the elderly. Medicare does not protect the aged from personally paying for much of their total health care needs, even for those services that we normally associate with Medicare coverage. For example, a large component of out-of-pocket costs is for nursing home care. If we look only at physician charges for covered services, we find that beneficiaries are directly liable for 60% of physician charges. This patient liability includes the annual deductible, co-payments for approved charges, excess billing for unassigned claims, and their Part B premium pro-rated for its contribution to Part B outlays.

Nearly all beneficiaries pay the Part B premium. Between 1977 and 1986 the Part B premium rose 116%. The 1987 annual premium is set at $214.80 - an increase of 15% over 1986.

The annual Part B deductible of $75 actually represents about $100 in out-of-pocket costs because only allowed charges count toward the deductible and the average reduction Part B claims is about 26.5%. Beneficiary liability for the 20% Part B co-payment more than doubled between 1980 and 1984. And, despite the participating physician program, charges associated with non-assigned claims totalled $2.6 billion in 1985 - an increase of 100% since 1980.

The Omnibus Budget Reconciliation Act of 1986 limits the amount by which physicians can increase their actual charges and seeks to bolster both those whose services are "under-valued" and maintain the participating physician program. The framework of this initiative should serve as the basis for payment reform. Beneficiaries would be best served with reform that:

- Achieves predictable costs for the beneficiary. Currently, beneficiaries rarely know what their costs will be for any given physician service. In turn, predictable costs will mean predictable payments for physicians.

- Retains the insurance concept of the Medicare program by sharing risk. This concept is key to future support of the program.

- Assures access to medically necessary services.

- Requires Medicare's payment for services to be accepted by physicians as payment in full once reform has been achieved. Beneficiaries should continue to pay some cost-sharing amount.

No one payment methodology (DRG's, fee schedules, capitation, etc.) will be appropriate for all types of physician services. In particular, hospital-based radiologists, anesthesiologists, and pathologists could be paid a prospectively determined fee with a probition against balance billing of patients. A mix of payment mechanisms would better assure quality of care by preventing the placement of all providers under the same economic incentives. In addition, any reform in payment policies will have to address not only price increases but also volume increases. We believe that reform can be achieved through the development of a Relative Value Scale.

Development of a Relative Value Scale & Inherent Reasonableness Application

A payment system based on a national Medicare Physician Relative Value scale (RVS) consisting of nationally defined units of service should be created. An RVS would create more predictable and rational payments than exist today. In addition, an RVS is a necessary prerequisite for determining fair compensation of any reform option such as capitation or other packaging arrangements.

The following proposals should be used as guidelines for the design of the RVS:

1. The establishment of a nationally defined set of physician services.

2. The establishment of a weighting mechanism which considers medical benefit in addition to cost of service and physician time and skill. In assigning weights, particular attention should be given to correcting current payment discrepancies such as the gap in compensation between procedures and cognitive and primary care services.

3. A mechanism for implementation of assignment for all physician services once fair and reasonable payment methodology is developed.

4. Payment increases in future years designed to maintain access.

5. A mechanism for regular recalibration and reconsideration of service definition, including a methology to adjust payments as the cost of technology and services change over time.

6. A mechanism for implementation of assignment for all physician services once fair and reasonable payment methodology is developed.

7. Legislation to include a description of the procedures to be followed in developing dollar conversion factors for the RVS, including a mechanism to assure that conversion factors are updated annually by a new measure of inflation to reflect changes in the cost of providing services.

8. The factors to be used by the Secretary in making "inherently reasonable" determinations should be specified and mandated. The Secretary should be required to improve payment for under-valued services as well as to decrease payments for over-valued services.

9. Legislation should provide for involvement of beneficiaries, physicians, and other interested individuals in the RVS development process and in "inherently reasonable" determinations. Requirements for adequate public comment periods and appropriate consultation with beneficiaries and physicians on proposed changes should be mandated.

10. Legislation, both short and long-term, should increase incentives for assignment and protect beneficiaries from further increases in costs and assure beneficiaries access to needed physician services.

11. The Secretary must be prohibited from promulgating any changes in the economic index formula until steps are taken to develop and implement alternatives to the economic index.

Other Steps for Payment Reform

Improvements in the Medicare program's participating provisions, such as strengthening the economic incentives to become a participating physician are important in creating incentives to participate. Reforms should enhance the role of Medicare as a prudent buyer of physician services.

Incremental implementation of payment reform through use of a transition system and by allowing for correction of certain payment problems to take place over a period of time is preferable to quick and sudden reform. In this manner, reform could be accomplished without unduly sharp or unpredictable changes in payment levels that could disrupt the continuing availability of physicians' services to beneficiaries.

While a payment reform for physicians is being developed, an interim reform of the current system under which rates of Medicare reimbursement for physician services are set should be considered. In particular, steps should be taken to reduce the discrepancy which has unnecessarily inflated physician care expenditures by fostering overutilization of technology-intensive procedure-oriented specialties.

Reform of physician payment under Medicare could best be achieved by following the principles outlined here. Any reform should culminate in a more easily understood methodology for fair and rational payment which services those the program was designed to assist -- the beneficiaries.

Testimony of
Edwin M. Cohn, M.D., FACC
National Affairs Chairman
of
The American College of Gastroenterology

Mr. Chairman and Members of the Subcommittee, the American College of Gastroenterology (ACG) thanks you for the opportunity to discuss our experiences with physician reimbursement under the Medicare program and to express some of our beliefs concerning physician payment reform.

Physicians have been forced to endure a Medicare fee freeze. Now, the freeze has been lifted, and an insubstantial increase has been allowed for physician services. Reimbursements are far from in line with costs required to provide these services. The cost of professional liability insurance alone has increased approximately 44.8% since 1983. Reducing the resources used to provide medical services has a devastating effect on the quality of services that physicians are able to render. Consequently, ACG strongly opposes any attempts to reinstate a fee freeze and supports an annual updating of fees for participating and non-participating physicians.

In addition to our concerns over the impact fee freezes have on quality of health care, the American College of Gastroenterology would also like to caution against substantially increasing the Medicare Part B deductible. In the long run, this would not be cost effective. Individuals would be more reluctant to seek the services they require, and in many cases, would not see a physician until their condition was severe. Thus, once a Medicare beneficiary finally does seek treatment for an illness, he or she will be sicker and require more costly treatment. Obviously, this is not within the realm of cost savings.

There are two other issues that ACG would like to comment on at this time. One is the issue of HCFA's inherent reasonableness criteria, which would allow reductions in physician reimbursement under Medicare below what would normally be allowed using the existing "reasonable charge" methodology set forth in Medicare law. Also, as you are probably aware, this proposal would further authorize the Secretary of Health and Human Services to establish national charge levels for particular services and "cost effective utilization rates". The American College of Gastroenterology recommends that Congress not support this proposed rule for the following reasons:

(1) Current Medicare law has established a specific methodology to be utilized for determining reimbursement for physician's services. Reimbursement is provided at the lowest of actual charge, customary charge, or prevailing charge. The Medicare statute does not authorize the Secretary of Health and Human Services to impose reimbursement levels which are not in accordance with this Congressionally developed methodology.

(2) This proposed rule would provide broad discretionary authority to the Health Care Financing Administration and result in arbitrary actions in limiting physician reimbursement.

(3) This proposed regulation would provide HCFA authority to reduce payment levels wherever it finds that the current reasonable charge methodology results in unreasonably excessive charges. Unreasonably excessive charges are subject to varied interpretation and therefore part of the vagueness of this proposed rule along with other language including what constitutes "cost effective" utilization and "other relevant factors."

The second issue that ACG would like to comment on is the requirement that laboratory tests performed in a physicians's office only be made on an assigned basis. ACG strongly recommends that this requirement be eliminated because it unnecessarily penalizes those physicians who are providing patients with a more timely test result in order to initiate treatment promptly. Obviously, instituting such a requirement could only result in a reduction of high-quality services.

Finally, the American College of Gastroenterology would like to point out that while today we have discussed a number of our concerns with certain proposals being considered, much of the current debate and recommendations for reforming the system are efforts which we wholeheartedly support. National organizations, such as the American Medical Association and the American Society of Internal Medicine, have suggested some alternatives to our present system that could improve our medical payment system. For example, the American Society of Internal Medicine is studying and developing a proposal to create a relative value scale system for physician services payment. Because of this initiative and others like it, we would expect that the physician community will be best able to suggest alternatives and would encourage Members of this Subcommittee to closely consider the alternatives suggested by the physician community. Of particular importance to ACG is that any revised physician payment system not be instituted at the expense of those individuals who seek the professional services of a specialist.

Again, the American College of Gastroenterology appreciates the opportunity to present our views. We would be happy to assist the Subcommittee in any way Members deem appropriate.

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

RE: Payment for Physician Services Under Medicare

March 3, 1987

The American Medical Association is pleased to have this opportunity to submit this testimony on the issue of physician reimbursement under Medicare. This issue is one that demands thoughtful analysis and discussion as part of a long-range proposal to restructure Medicare into a solvent program for all of our nation's future generations.

The AMA is exceedingly displeased with the directions being taken by the Administration in its search for ways to "reform" physician reimbursement under Medicare. In simple terms, physicians are angry over the piecemeal and shortsighted steps taken or proposed that are designed only to achieve arbitrary budget savings seemingly without any consideration given to the impact of these changes on either the beneficiary or the physician.

We have had and continue to have serious reservations over many of the recent legislative modifications in physician reimbursement under Medicare. Nevertheless, we strongly support the direction taken in the last two Reconciliation Acts calling for a thorough analysis of physician reimbursement under Medicare and the development of a resource-based relative value scale (RVS).

The American Medical Association fully recognizes that current physician reimbursement methodologies must be analyzed with a close eye to eliminating many of the problems inherent in the way physician reimbursement is determined. We recognize that the current methodology both over and under compensates at times. To this end, the AMA is acting as a subcontractor in the development of a resource-based RVS being developed under a cooperative agreement between HCFA and Harvard University. This study is due to be completed by July, 1988. In addition to this private sector study, the Secretary of HHS has been instructed by Congress, through COBRA and OBRA, to develop a resource-based RVS by July 1, 1989 and to discuss possible implementation of this RVS by January 1, 1990.

The American Medical Association supports these efforts to move to a resource-based RVS as the basis of Medicare physician payment reform. Such a study has the best opportunity of removing inequities in the reimbursement structure and in eliminating the obvious confusion surrounding the existing system. Congress could consider an interim charge-based RVS as the basis for a Medicare schedule of payments. Such an indemnity reimbursement system, one that recognizes geographic variations in practice costs and the need for annual updates, would have several immediate advantages. It would reduce uncertainties facing both beneficiaries and physicians as to what Medicare actually will pay and it will decrease administrative expenses. Assignment on a case-by-case basis could continue to be available. As an element in adopting any interim RVS, Congress should incorporate a specific timetable for converting to the resource-based RVS.

Before turning to the Administration's budget proposals, we feel it is imperative to again remind the Committee that the Medicare program is still rapidly heading into bankruptcy. While we recognize the need for short-term savings to shore up the Medicare program, overall Medicare reform is necessary to assure the existence of a sound health care program for all of the coming generations of elderly.

The AMA has developed detailed proposals, both short-term and long-term, (attached) that address these issues and present rational proposals for Medicare reform. It is time to put Medicare reform on the front burner and to remove this program from the annual series of program cuts that are aimed solely at generating arbitrary budget targets and ignore the impact of the action on access to and quality of care.

ADMINISTRATION BUDGET PROPOSALS

The Administration's FY88 budget proposal calls for a number of substantial modifications in the Medicare program to "save" $4.7 billion in the next fiscal year. Quite frankly, we are appalled at such an unbalanced approach to our nation's budget problem. This Administration's budget continues the past policy of balancing the budget on the backs of the Medicare and Medicaid programs, with these programs being cut at a rate nearly double their share of total federal expenditures. We have joined with the American Association of Retired Persons, the American Hospital Association, the American Nurses Association, and the Federation of American Health Systems in urging Congress to be fair with Medicare and Medicaid and avoid further senseless budget cuts.

In this statement, we will focus our further comments on the physician reimbursement proposals in the budget.

DRG-based Payment for Radiology, Anesthesiology, and Pathology Services (RAPs) Provided to Hospital In-patients

The AMA is unalterably opposed to a DRG-based physician payment plan. This approach to physician payment remains totally untested. Every indication is that such a system will be detrimental to both access and quality. As the DRG payment for physician services would be based on an "average" for the mythically "average" patient, the program will increase the already tremendous hospital driven economic pressures for withholding care in the hospital.

- Incentives caused by hospital DRGs already have limited the availability of services, as evidenced by nursing and other services having been pared by hospitals. RAP DRGs will create new incentives to now limit access to physician services.

- By basing payment for both physicians and hospitals on DRGs, all of the economic incentives will be weighted against the patient, i.e. by providing fewer services, the hospital stay becomes more "profitable."

- DRGs do not pay for services actually rendered; in fact, they reward for services not performed. This mechanism will reinforce existing hospital incentives to reduce available care and avoid severely ill patients.

- RAP DRGs are unnecessary as a means for controlling utilization. Medicare now has the authority to deny payment where it determines that a service is not "medically necessary."

- Beneficiaries who use little or no services will be penalized by having to pay higher coinsurance than under the current system, while those who use substantial RAP services will benefit from a fixed coinsurance that is unrelated to the services received.

- Access to care in rural areas will suffer. RAP physicians will be discouraged from providing services in areas distant from their primary site of practice. Many rural hospitals already experience hardships due to the existing DRG payment methodology. It is dangerous to further expand the DRG payment to services provided in hospitals already in crisis.

- The savings attributed to this proposal cannot justify the resulting disruption in patient care activities and the serious risk patients will face by their loss of access to RAP services.

- RAP DRGs will be detrimental to patient care by driving a wedge into the physician/patient and physician-to-physician relationships.

In addition to these points, experts on physician reimbursement issues outside of the medical community have indicated strong concerns over physician DRG proposals.

- Implementation of a physician DRG system would too closely align the incentives of physicians with hospitals. This might well result in the physician not continuing to be as strong an advocate for needed medical services to be given the beneficiary in the hospital, and reduced access of beneficiaries to hospital care if hospitals practice "skimming", i.e., admitting large numbers of patients who require less care than average for the DRG, while referring elsewhere beneficiaries who require more care than average. (Jennifer O'Sullivan and James Reuter, Congressional Research Service of the Library of Congress, Background Paper for The Senate Finance Committee, April 22, 1986)

- Close alignment of the incentives of the hospital with those of the medical staff could be very expensive for the current prospective payment system and might create access problems for potentially unprofitable patients. (Stephen F. Jencks, M.D. and Allen Dobson, Ph.D. [Office of Research, HCFA)], New England Journal of Medicine, June 6, 1985)

- If physician DRG payments are made to the hospital and the hospital allocates funds to the physician, this would reduce the patient advocacy role of the physicians, and reduce his efforts to provide protection against excessive hospital cost cutting. (Stephen F. Jencks, M.D. and Allen Dobson)

- If the growth of Medicare costs is concentrated in outpatient services, as recent unpublished HCFA data suggests, an inpatient physician DRG system is less useful. (Stephen F. Jencks, M.D. and Allen Dobson)

- Implementation of a physician DRG system would not be feasible until a case-classification system suitable for physician services could be developed -- a very difficult task. (Congressional Budget Office Report, "Physician Reimbursement Under Medicare: Options For Change," April, 1986)

- Physician DRG system would align physician incentives too closely with those of hospitals, with the result that physicians might not serve as effectively as advocates for beneficiaries. (CBO)

Finally, the Administration's proposal is not responsive to Congressional direction and is certainly premature. Congress has rejected and should continue to reject such major physician payment reform not backed by appropriate study.

- Congress in 1983 called for a study and report on MD DRGs -
  - The report, due in 1985, has not been given to Congress. However, a draft of the unpublished HCFA report states: "DRG based payment to physicians is inadvisable because it would be difficult to put in place, complex to administer and unpredictable in its impact." (Emphasis added.)

- Congress in 1986 created the Physician Payment Review Commission to study and report to Congress on physician reimbursement -
  - The Commission's first report was submitted on March 1, 1987.

- Congress in 1986 called for a study and report on RAP DRGs -
  - This report is due by July 1, 1987.

House Concurrent Resolution 30, with widespread bi-partisan co-sponsorship, clearly states that it is neither feasible nor desirable to implement any method of payment for physicians services based on DRGs. We urge the Members of this Committee to join with us, the American Hospital Association, the Federation of American Health Systems, and your colleagues in speaking out against physician DRGs through prompt passage of this Resolution.

13% Reduction in the Medicare Prevailing Charge Level for Cataract Surgery

We urge you to reject the proposal to impose a further 13% cut in the Medicare prevailing charge for cataract surgery. This Administration proposal comes immediately on the heels of legislation just enacted that made a 10% cut in the prevailing charge for these services for the 1987 fiscal year with a further 2% cut scheduled for fiscal year 1988. Over the past four years, cataract surgery has been the particular target of budget cutters.

The jury still is out over the impact of last year's cutting in the overall reimbursement level and payment level for the services. Yet it is clear that this cut as well as the further proposed cuts fail to discriminate between areas of low or high costs. In addition, there are outstanding questions over the implementation of last year's proposal as a number of non-cataract procedures have been subjected to the 10% cut.

Setting Customary Charges of New Physicians at "about 80%" of the Prevailing Charge

The AMA opposes the Administration's proposal to set customary charges for new physicians at "about 80%" of the prevailing charge level. Current law sets these rates at the 50th percentile of area-wide customary charges. The Medicare prevailing charge historically has been held down by modifications in the program over the past 18 years, including the application of the Medicare economic index. The full so-called "prevailing" charge level, let alone 80 percent of this amount, does not reflect the actual cost of providing a service, and is frequently below the 50th percentile of area customary charges.

It would be totally unfair to arbitrarily set a physician's customary charge at 80% of the prevailing charge level simply based on the year in which that physician entered practice. This proposal could discourage physicians from providing care in areas currently underserved, as it would be next to impossible for them to recoup the start-up costs of practice, educational expenses and other costs when treating Medicare beneficiaries. Of major importance, this proposal, if anything, acts as a disincentive to provide care for the Medicare population.

Other Physician Reimbursement Changes

The Administration's budget also calls for reductions to be made in physician reimbursements in instances where: the charges are "overpriced" compared to other procedures; the charges vary excessively from one location to another; global surgical fees that are not reflective of reductions in hospital lengths of stay; and there is a large disparity between the charges of a specialist and a non-specialist. The types of reductions discussed in this proposal relate to the inherent problems in the current methodology for determining physician payment under the Medicare program. These problems need to be addressed in a comprehensive and not a piecemeal manner. We urge you to reject these shortsighted and arbitrary proposals, and to await completion of a resource-based RVS.

CONCLUSION

The AMA is concerned that hasty actions in the physician reimbursement arena will result in unintended results that could prove detrimental to Medicare beneficiaries. By way of example, throughout the nation physicians experiencing severe practice problems from the application of the MAAC limits due to the substantial rollbacks in what they are allowed to charge Medicare beneficiaries. We are concerned that some physicians will find it economically impossible to continue treating Medicare beneficiaries. While the elderly in some areas may be able to find a new physician to provide care, this will not be the case nationwide. Both patients and physicians will be losers if a short-sighted Medicare reimbursement policy forces a break-up of long-standing patient/physician relationships. Our nation can ill afford a continuation of such policies.

We urge this Committee to look at past actions and correct inequities that have resulted and also to consider the potential inequities that could result from the Administration's budget proposals and to reject them as well.

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MEDICARE SAVINGS AND REVENUE PROPOSALS

The following potential revisions to the Medicare program, supported by the American Medical Association, could generate substantial program savings and revenue: approximately $28.6 billion in FY88.

1. Modifications to Medicare Part B Premium (savings of $571 million in FY88) - The Administration, in its FY88 budget proposal, proposes modifying the Part B premium by establishing three separate premiums: 1) 35% of program costs for new enrollees; 2) 35% of program costs for current beneficiaries; and 3) 50% of program costs for third-party payors.

   The AMA supports increases in the Part B premium to fund at least 35% of program costs. The Association is concerned about an immediate increase in the premium to 50% for third-party payors. Such an increase could prove onerous to states that buy into the Medicare program for all eligible Medicare and Medicaid beneficiaries. There should be a variable Part B premium, based on an individual's resources to achieve the 35% funding level.

2. Index Part B Deductible to the Medicare Economic Index (savings of $25 million in FY88) - Under current law, beneficiaries must pay an annual Part B deductible of $75 before expenses will be paid by Medicare. The Administration, in its FY88 budget proposal, proposes indexing this deductible to the Medicare Economic Index.

   The AMA supports an adjustment to the Part B deductible. However, adjustments should be based on an index that appropriately measures changes in medical care costs.

3. Include State and Local Employees Hired After March 31, 1986 Under Medicare (revenue increase of $1.600 billion in FY88) - COBRA mandated Medicare coverage and payment of Hospital Insurance taxes for state and local government employees hired after March 31, 1986. The Administration, in its FY88 budget proposal, proposes making Medicare coverage and Hospital Insurance taxes mandatory for all state and local employees.

   The AMA supports this proposal.

4. Repeal of Specified Provisions in OBRA (savings of $323 million in FY88) - The Administration, in its FY88 budget proposal, proposes to repeal OBRA provisions that extend Medicare Part B coverage to include vision care services performed by optometrists, and include the services of, and separate payment for, physician assistants.

   The AMA supports this Administration proposal. The Association previously has expressed concerns over the expansion of the Medicare program, especially at a time when the focus of legislative proposals has been to cut program expenditures.

5. Extend Medicare as Secondary Payor for Disabled Beneficiaries who Work for Medium-Sized Employers with Employer Group Health Insurance (savings of $120 million in FY88) - OBRA made Medicare the secondary payor for the disabled who are covered by large employer-based (100 or more employees) health plans. Family members of such employees are also covered under this provision. The Administration, in its FY88 budget proposal, proposes extending Medicare as secondary payor to disabled beneficiaries and their families who have coverage from a medium-sized employer-based (20 or more employees) health plan.

   The AMA supports this proposal. The Association notes that beneficiaries would maintain the option of having Medicare operate as the primary coverage. The Association has previously supported similar proposals.

- American Medical Association -
Department of Federal Legislation, Division of Legislative Activities

6. Begin Medicare Coverage on the First Day of the Month After Age 65 is Achieved (savings of $295 million in FY88) - The Administration, in its FY88 budget proposal, proposes delaying eligibility until the first day of the month following the month in which the beneficiary turns age 65.

   The AMA supports this proposal.

7. Repeal of "Mandated Assignment" for Office Clinical Laboratory Procedures (savings of $35 million in FY88) - COBRA requires assignment to be accepted as a condition of coverage for laboratory procedures performed in a physician's office. Medicare beneficiaries who benefit from laboratory procedures performed in a physician's office are unduly discriminated against because a medically necessary service may not be covered if an assignment is not accepted. Repeal of this requirement also will generate program savings, as (prior to the law change) non-assigned claims for clinical laboratory services provided through a physician's office were reimbursed at 80% of the allowed fee schedule amount, with beneficiaries being liable for applicable coinsurance. Assigned claims for the services were paid at 100% of the fee schedule amount.

   The AMA supports this proposal.

8. Increase the Payroll Tax Rate (Revenues of $9 billion in FY88) - Under current law, the HI trust fund is principally funded through taxes paid by workers, employers, and by individuals with self-employment income. The tax rate that both employees and employers must pay is 1.45 percent each, or a combined 2.9 percent rate. The tax rate for self-employed is 2.6 percent. Government actuaries have estimated that the combined health insurance payroll tax rate would have to be increased to 5.13 percent buy 2005 in order to completely cover program expenditures by that date.

   Consistent with the concept that payroll contributions should have more relationship to future benefits received, the AMA supports a modest increase in the health insurance payroll tax rate. For example, an additional increase of one quarter of one percent to both employer and employee (0.5 percent combined) is entirely appropriate as part of an overall solution to ward off impending program bankruptcy.

9. Increase the Tobacco Excise Tax (Revenue of $3.5 billion in FY88) - The federal excise tax on cigarettes is now $0.16 per pack.

   The AMA supports an increase in the present tax rates for tobacco products to $0.32 a pack, with the additional revenues directed to the Hospital Insurance trust fund. The Association repeatedly has emphasized the need for treating addiction to tobacco as a serious medical problem, and for multifaceted efforts to prevent this physically and socially detrimental behavior pattern. The AMA's Council on Scientific Affairs estimated that 346,000 U.S. deaths in 1979 were attributable to smoking.

10. Taxing Non-wage Income (Revenue unknown) - The present HI tax is levied only on payroll and self-employment income. Non-wage income, such as interest, dividends, etc., is not affected and should be added to taxable income to determine the Medicare tax.

    The AMA supports imposing the Health Insurance tax on the non-wage income of individuals above a certain threshold. This excess should become part of income to determine the Medicare tax. Equity and fairness require that all citizens face the same relative tax burden to fund the program, regardless of the source of their income. (Exempting an appropriate amount, e.g., the first $10,000 or $12,000 of non-wage income, would avoid first dollar taxation on non-wage income of retirees.)

11. Modified Part A Coinsurance with Cost-sharing Limits ($12 billion in revenue in FY88) - Medicare beneficiaries run the risk of high out-of-pocket payments for long stays in the hospital due to severe illnesses. Imposing beneficiary coinsurance for certain hospital days beyond the first, up to a dollar maximum beyond which Part A would pay full hospital costs of whatever duration, could provide the coverage for catastrophic hospital care expenses now lacking under Part A, depending on the coinsurance and cost-sharing limits selected.

    The AMA would support coinsurance for Part A hospital expenses up to a cost-sharing limit, with the cost-sharing amount varying according to beneficiary income status.

12. Raising the Age of Medicare Eligibility (savings of 1.1 billion in FY88) - Current law provides for incrementally increasing the age of eligibility for full Medicare benefits to age 67 over the years 2005-2027. While savings generated by this step-up have no immediate significant impact on depletion of the Part A trust fund, beginning the age step-up at an earlier date could generate significant additional program savings.

    The AMA supports an incremental increase in the age of eligibility for Medicare benefits beginning as soon as practical. Longer terms of employment, improved health status and longevity of the population amply justify raising the age of Medicare eligibility. Special consideration should be given to coordinating eligibility dates for Medicare and Social Security cash benefits and to assuring continued private health insurance coverage for retirees who have yet to achieve Medicare entitlement age.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE TO THE SUBCOMMITTEE ON HEALTH, WAYS AND MEANS COMMITTEE FOR THE RECORD OF THE REPORT TO CONGRESS OF THE MEDICARE PHYSICIAN PAYMENT REVIEW COMMISSION AND ON FISCAL YEAR 1988 BUDGET ISSUES RELATED TO PHYSICIAN PAYMENT UNDER THE MEDICARE PROGRAM

Introduction

The American Society of Internal Medicine (ASIM) appreciates the opportunity to express the views of internists throughout the country on alternative payment methods for physician services under the Medicare program.

In the years since ASIM was founded in 1956, the Society has played a leading role within the medical profession in studying and formulating innovative approaches to paying for physician services. During the past six years in particular, the Society has devoted considerable time and resources to identify the problems in the current system of payment for physician services--and developing constructive proposals to address and resolve those problems. In this process, ASIM has developed specific objectives and principles on payment for physician services that can serve as a basis for legislation to alter the current system of payment under the Medicare program.

On several occasions during the past year, ASIM has shared some of its recommendations with this Subcommittee. Although ASIM believes that it is important to re-emphasize and expand on some of those recommendations, this statement will focus primarily on several new developments affecting payment for physician services under the Medicare program. Those developments are:

- o The release of the first annual report to Congress by the Physician Payment Review Commission (PhysPRC).
- o The limits on actual charges of nonparticipating physicians--the so-called maximum allowable actual charge (MAAC) limits--included in the Omnibus Budget Reconciliation Act (OBRA) of 1986.
- o The proposal by the Reagan Administration to begin paying for physician services through the hospital prospective pricing system (PPS) based on DRGs.

Report of the Physician Payment Review Commission

ASIM believes that the recommendations and analysis in the Commission's March 1 report to Congress merit serious consideration by Congress. The Commission has done an admirable job of defining the problems with the existing system of payment and identifying opportunities for short- and long-term reform. It is clear that the Commission has approached its responsibilities with the degree of careful deliberation and responsiveness to the concerns of beneficiaries, physicians, and others that is needed to come up with workable solutions to the problems facing the existing payment system. The Society was particularly struck with the clarity of the Commission's discussions and recommendations and what it was able to accomplish in a relatively short period of time. Moreover, ASIM is generally comfortable with the analysis, direction, and recommendations in the report. More specifically, ASIM has the following comments on areas addressed in the report:

Goals for Physician Payment Policy

ASIM believes that the goals identified by the Commission are appropriate (pages 2-3 in the Commission's report). The Society is particularly pleased that the report recognizes the importance of maintaining free choice of physicians for those beneficiaries electing to continue to receive care through the fee-for-service system; protecting beneficiaries from reductions in quality of care that can result from payment reforms; maintaining financial protection for beneficiaries; providing for equity among physicians, by assuring that differences in payments for different services broadly reflect relative costs, market conditions, and other appropriate factors; bringing about greater understandability in the payment system (ASIM is already on record as supporting the concept that physicians and beneficiaries should know what Medicare will allow, and beneficiaries should in turn be informed by physicians--preferably in advance of services--as to what they are expected to pay); and maintaining pluralism, with both fee-for-service method and capitation playing a role in delivery of medical care. Moreover, ASIM strongly supports the Commission's conclusion that:

> Current differences in charges for physician services send distorted signals to physicians and cause serious inequities among physicians. These distortions and inequities may affect physicians' decisions concerning what services to provide, what specialty to train for, and where to locate a medical practice. These problems result from a market in which consumers have difficulty in shopping for prices and where uneven insurance coverage obscures the signal consumers are able to deliver. Careful attempts to develop relative value scales that take into account factors in addition to existing patterns of charges may lead to relative payments that will provide more appropriate signals to physicians.

The Society's views on ways to correct those distorted signals and incentives will be discussed in greater detail below.

Fee Schedules

ASIM strongly supports the Commission's endorsement of the concept of a fee schedule for paying for physician services to Medicare beneficiaries, with relative payments for services, locations, settings, and perhaps specialties differing from the patterns of allowed charges under the current system. (The Society prefers, however, that the term "schedule of allowances" be used in lieu of "fee schedules," since the latter can be misinterpreted as an endorsement of mandatory acceptance of the "fee schedule" amounts as payment in full--something that neither the Commission nor Congress has been inclined to endorse at this time.) It is understandable that the Commission has not yet had the opportunity to examine several issues of design and development that are essential to the development of an appropriate and acceptable schedule of allowances. Nevertheless, ASIM is generally pleased with the general direction of the Commission's discussion of several basic issues involved in the development of a fee schedule.

The Commission's discussion (page 34) concerning the potential for a schedule of allowances to improve incentives, in particular, merits the careful attention by Congress. ASIM agrees with the Commission that under the current "customary, prevailing, and reasonable charge" (CPR) system, "some services are reimbursed more generously relative to cost than other services. . . A fee schedule could change relative payments for services and the associated incentives, and potentially improve the effectiveness of medical practice. A fee schedule with payments more in line with costs would reduce the financial incentive to provide one service over another, leaving the choice of services to be determined by the physician's medical judgment and patient's preferences."

For years, ASIM has strongly argued for the development and implementation of a resource cost based schedule of allowances as a basis of payment under Medicare. Such a system would correct the negative incentives cited by the Commission in its report. By developing a relative value scale (RVS) based on resource costs--which in turn would be used to construct a schedule of allowances by the inclusion of appropriate dollar conversion factors--Medicare for the first time would have a relatively simple, understandable, and predictable system that would reduce the distortions in the relative values of cognitive and procedural services.

Cognitive services--a term which describes the processes of problem solving; applying diagnostic skills of comprehensive history and physical examinations; data collection and analysis; therapeutic assessment and case management; patient and family counseling; and ongoing compassionate care of patients--have always been paid for at lower rates than technical services. Health insurance was originally created to protect patients from the high cost of hospitalization and later, from the cost of surgery. Benefits were later expanded to cover procedural services, such as laboratory tests. Since charges for cognitive services were not covered, they remained low so as not to produce serious strain on the family budget. Physicians, finding that diagnostic and therapeutic assessments were not covered, also began to place more emphasis on charging separately for laboratory tests, ancillary procedures, and other covered services. In marketing terms, the office visit became an unconscious "loss leader." This disparity continues today: a 1979 study funded by HCFA--and a more recent study funded by the Massachusetts State Rate Setting Commission--found that cognitive services such as office visits are undervalued by a factor between two and three to one compared to surgical procedures.

As a result of this distortion in the relative values of cognitive and procedural services, a physician who orders or performs an expensive array of technology-intensive services is well compensated. A physician who spends time with a patient, carefully assessing his or her need for further tests and procedures, is penalized for that style of practice. Logic and research both tell us that reducing incentives to provide technology intensive care will result in fewer tests being ordered, fewer procedures being performed, and in all probability, fewer instances of hospitalization. This conclusion is supported by a large body of expert opinion and research. ASIM will be pleased to share with the Subcommittee some of the literature that supports this view.

A resource cost payment system--by placing more reward on time consuming, complex "cognitive services" in comparison to technical procedures--would be a major step toward reducing incentives for overutilization of high-cost technology, thus making fee-for-service under Medicare a far more cost effective payment option than is now the case.

Given the widespread consensus in favor of developing a schedule of allowances that more closely reflects resource costs, ASIM strongly believes that Congress should refrain from implementing any major changes in the existing payment system under Medicare until the resource cost based RVS, under development by Harvard University, is available for implementation. Congress itself has recognized the importance of this study, by including in OBRA provisions that delay until January 1989 the requirement that the Secretary develop a relative value scale as a basis for payment under Medicare (thus allowing for completion of the Harvard study), and by calling for the MAAC limits to be phased out as soon as the RVS is completed. Moreover, over 200 members of the House of Representatives have cosponsored a resolution (H. Con. Res. 30) that would put Congress on record as opposing any additional major changes in the payment system until the resource cost study is completed and ready for implementation. Although this does not preclude Congress or the Commission from continuing to review alternative methods of developing a schedule of allowances, or considering other long-term alternative methods for reforming the payment system, ASIM believes that the confidence in the resource cost methodology is well placed. Moreover, ASIM continues to support appropriate measures to begin bringing some rationality into the payment system during the period of time that the resource based RVS is in the development.

ASIM also agrees with the Commission there is "little merit in RVSs or fee schedules based solely on historical Medicare prevailing charges" since such methodologies would simply "institutionalize current relative values" (page 37). The Society similarly agrees that a location multiplier under such a fee schedule should vary among regions, states, or carrier areas. As explained by the Commission, if differences in allowed charges among different locations accounted only for differences in the cost of providing services, the schedule of allowances would not provide financial incentives for physicians to locate in one geographic area instead of another.

The Society also agrees that a schedule of allowances would have to be updated over time as new services are added and relative values and multipliers change. One of the major concerns that physicians and beneficiaries have about replacing CPR with a schedule of allowances is that the Administration or Congress, solely for budgetary reasons, might freeze conversion factors, with a potential disruption in the quality and availability of medical care provided to patients. Therefore, ASIM strongly believes that conversion factors should be updated on at least an annual basis to reflect changes in the cost of providing services. The Society also agrees with the Commission that several other issues--including improvements in the coding system; methods to limit the use of unnecessary services and to control total program expenditures; the method for changing the relative values, multipliers, and conversion factors over time--require additional study. The Society plans to work closely with the Commission and Congress in addressing those questions.

Geographic Variations in Charges

The Commission recommends, as an initial step to deal with geographic variations, that Medicare pay an increment beyond approved charges for primary care services delivered in designated underserved areas, and further suggests that these additional incremental payments will not affect coinsurance amounts and that they could be financed by a slight reduction in the MEI factor.

ASIM agrees that the current payment system is inequitable in that physicians with comparable training and experience can receive substantially different payments while providing the same service, a pattern that apparently persists even after accounting for cost of practicing or cost of living differences. As noted by the Commission, this inequity has been exacerbated by across-the-board freezes and reductions in payments that constrain all physician fees, high and low alike. Therefore, ASIM is intrigued by the Commission's recommendation for an initial selected increase in payments for certain primary care services in underserved areas as a way of addressing these disparities. ASIM suggests, however, that Congress consider several modifications in the Commission's recommendation:

- Since it is generally agreed that primary care services are relatively undervalued nationwide, Congress might consider an incremental increase for such services in all localities, not just in medically underserved areas. ASIM believes that there is strong evidence to support the conclusion that primary care services are relatively undervalued in virtually all localities. Moreover, the designation by the Department of Health and Human Services (DHHS) of medically underserved services is intended to identify certain areas where patient access to physician services is inadequate, due to an undersupply of physicians. It was never intended as an identifier of locations where primary care services are underpaid. Although it can be expected that many of those areas have disproportionally low payment levels for primary care services, it is also quite possible--even likely--that there are other areas not designated as "underserved" where primary care services are paid disproportionately low compared to other localities, even accounting for differences in cost of practice and living. Therefore, ASIM suggests that Congress consider expanding this recommendation to improve payment for selected primary care services nationwide.

- Congress should consider financing the increase in those primary care services by some means other than a slight reduction in the overall MEI update factor. Given that the MEI for nonparticipating physicians has been increased only once (by only 3.12 percent) from July 1, 1983, through December 31, 1986--a time when overhead costs incurred by physicians outpaced the inflation rate--ASIM believes that a further reduction in the MEI is not the most appropriate way to finance the increase in selected primary care services. Moreover, this would have the adverse impact of reducing increases in reimbursement for already undervalued cognitive or primary care services in areas of the country not designated as "medically underserved."

Inherent Reasonableness

ASIM agrees with the goals of inherent reasonableness endorsed by the Commission:

- To redress distortions in allowed charges that have arisen through the application of CPR reimbursement principals and

- To achieve short-term budget savings in ways that are more consistent with long-term policy directions than are across-the-board reductions in payments.

Moreover, ASIM strongly agrees that in order for these goals to be reached, inherent reasonableness must be applied carefully through an open process that takes into account input from all interested parties.

ASIM is particularly pleased that the Commission recognizes that application of inherent reasonableness will increase allowed charges for some services as well as reduce allowable charges for others. Inherent reasonableness, if properly designed, can represent an important, interim approach to correcting, on a selected basis, certain inequities in the existing payment system, such as inappropriate geographic differentials and the disparity between cognitive and procedural services. Unfortunately, the Reagan Administration appears to view this process primarily (or solely) as a method of reducing expenditures, not redressing distortions and inequities in the CPR system. Using the inherent reasonableness process to improve payment for certain undervalued services, as recommended by the Commission, would be an important signal to physicians and beneficiaries that this process is intended as something more than another way of ratcheting down federal spending on Medicare Part B services.

The Commission's proposed consensus approach to making inherent reasonableness determinations may represent a viable alternative to the process established by the August 11, 1986, final rule and OBRA. ASIM believes, however that it is essential to preserve OBRA's mandate that adjustments be made on the basis of estimates of relative charges and relative resource costs. In addition, the composition of the consensus panels will be critical for the proposed adjustments in payment levels to have credibility with physicians, beneficiaries, and others. Therefore, ASIM welcomes the opportunity to work with the Commission in developing and studying a consensus approach to making inherently reasonable determinations. The Society sees no need, however, for Congress to amend the requirements in the OBRA law until such time as the Commission has had an opportunity to test its consensus approach and advise Congress, in its next annual report, on the advisability and feasibility of this alternative and any necessary changes in enabling in legislation.

Assignment and the Participating Physician Program

ASIM agrees that there is a need to identify ways to improve physician willingness to accept assignment or to discount fees, particularly for services provided to low-income beneficiaries. It is important to understand, however, that acceptance of Medicare assignment is at an all-time high, with almost 70 percent of all claims being accepted on an assigned basis. Therefore, ASIM believes that the problem of beneficiary out-of-pocket liability for physician services should not be overstated. There is considerable evidence, in fact that those patients for whom physicians are not currently accepting assignment tend to be wealthier, healthier, and younger beneficiaries. ASIM believes that Congress' and the Commission's efforts to improve acceptance of assignment should be directed towards those Medicare beneficiaries who, due to low incomes, cannot afford to pay physicians' full fees.

Although ASIM is pleased that the Commission has not endorsed mandatory assignment for physician services--instead preferring to monitor the impact of the recent policy changes affecting assignment--the Society is concerned that the Commission's recommendations and Congress' most recent actions are directed primarily towards encouraging enrollment in the participating physician program.

Given the fact that less than one-third of all physicians have signed up to become "participating" physicians, it is clear that much of the recent increase in assignment rates is due to the efforts of nonparticipating physicians to accept assignment on an increasing proportion of their Medicare patients. Since most Medicare beneficiaries receive care from nonparticipating physicians--and are likely to continue to do so for the foreseeable future--it seems reasonable that efforts should be made to encourage increased acceptance of assignment on a claim-by-claim basis by nonparticipating physicians, rather than simply attempting to expand the pool of participating physicians. Although in time more physicians may sign up to become "participating" if sufficient incentives are provided, ASIM believes that many physicians will continue to exercise their option to accept or not accept assignment on an individual claim-by-claim basis.

There are many reasons that individual physicians may decline to become "participating." Many physicians, for example, have a mix of relatively wealthy Medicare patients and those with more limited means. The individual claim-by-claim assignment option allows physicians to accept assignment on those in need while charging their usual fee to those who can afford to pay it. For those physicians, maintaining the flexibility to do so is a critical factor in their decision not to become "participating" physicians. Other physicians are unwilling to become "participating" physicians because of a concern that it removes the patient from the equation, thereby weakening the doctor-patient relationship. Still others do not participate simply because they cannot afford to accept Medicare's payment levels for all services as "full payment."

For all of these reasons, a strategy based solely and simply on expanding the participating physician program is likely to fail, since it does not address the needs of the vast majority of patients who will continue to receive care from nonparticipating physicians. Therefore, ASIM strongly recommends that Congress explore ways to increase acceptance of assignment under the claim-by-claim option, particularly for those low-income patients who truly need such protection. This should include study of those factors that influence a physician's decision whether or not to accept assignment for a service provided to a given patient. The role of voluntary programs to improve the predictability of the assignment option should also be considered. ASIM, for example, has initiated a program titled, "Personal Care," by which enrolled physicians agree to discuss assignments and fees in advance of rendering services, whenever possible; to assist patients in filing unassigned claims; and to either discount fees to Medicare's approved amount or to accept assignment for services provided to low-income patients. A description of the program is appended to this statement. Such voluntary efforts may go a long way toward improving the predictability of the assignment option and assuring low-income beneficiaries that their needs will be accommodated within the claim-by-claim option.

Improving Program Administration

ASIM strongly supports the Commission's recommendations for improving carrier administration. The Society has initiated its own project--the Carrier Accountability Monitoring Project--to identify instances where Medicare carriers are administering the program in an ineffective and inefficient manner. The Commission's recommendations for more appropriate funding levels; stronger standards for carrier claims processing; elimination of persistent poor performers; and expanded research to identify cost-effective utilization review methods are all appropriate. ASIM suggests, however, that the Commission and Congress recognize the importance of carriers and HCFA working with professional organizations in developing utilization review criteria. It is ASIM's belief that where carriers have worked with physicians in developing utilization criteria, such criteria have been far more acceptable to the practicing physician community. Those carriers, on the other hand, that have simply developed utilization review criteria on their own, and then announced them as a "fait accompli" to physicians, have found that the willingness of practicing physicians to comply or cooperate with the criteria has been very limited.

The Society also believes that Congress must recognize that much of the problem in Medicare carrier performance is due to the way Congress itself has imposed short-term, stop gap measures in order to achieve budgetary objectives. The maximum allowance charge limits (MAACs) program included in OBRA is an example of a legislative mandate that is unnecessarily complex and difficult to administer. The enormous problems that the MAAC program has created for carriers and physicians are discussed in detail below. Although some of these problems are due to poor carrier performance, Congress must accept responsibility for mandating a program that apparently was beyond the administrative capabilities of most Medicare carriers. Consequently, ASIM suggests that in the future, Congress carefully consider the capacity of the Medicare program to effectively and efficiently implement proposed legislative changes before enacting such mandates.

Maximum Allowable Actual Charge (MAAC) Program

As part of the Omnibus Budget Reconciliation Act of 1986, Congress mandated that limits be maintained on the actual charges to Medicare patients of nonparticipating physicians. It established a complex formula for determining how much physicians can charge each year, based upon a comparison of the physicians' customary charges and Medicare's prevailing charges. Congress intended that those physicians whose charges customarily fell below Medicare's prevailings would be able to "catch up" by incremental increases in their charges over the next four years while those who charge more than 115 percent above their prevailings would be limited to annual increases of 1 percent above their current charges.

In the first three months since the MAAC program became effective, however, it has become apparent that the law is causing major disruptions in Medicare's system of payment for physician services. Since the law was enacted, ASIM has received literally thousands of letters and phone calls from member-internists describing problems they have experienced with the MAAC program. Based on a careful review of the communications and documentation received from those members, ASIM has reached the following conclusions:

1. **The MAAC program is in conflict with the goals of physician payment reform outlined in the March 1 report of the Physician Payment Review Commission—goals that Congress presumably share.** The Commission stated that reform should make the method of paying physicians easier for beneficiaries,

physicians, and the general public to understand; the MAAC program conversely is extraordinarily complicated and difficult to comprehend, even by the Medicare carriers that are responsible for implementing the program. While the Commission states that reforms in the method of payment should be orderly and coherent, implementation of MAACs has been both disorderly and incoherent. Contrary to the goal established by the Commission, the feasibility of administering the MAACs apparently was never given adequate consideration by Congress when it established the methodology for determining charges and in setting a schedule for implementation. Moreover, instead of furthering the Commission's goals of increasing equity among physicians so that similar payments are made for similar services among similarly qualified physicians, the MAAC provisions have created greater inequities and distortions in charges for physician services. Although Congress did not have the benefit of the goals articulated by the Commission when it enacted the MAAC limits, ASIM believes that it is essential that Congress now re-evaluate the program according to the goals stated in the March 1 report to Congress. As the Commission itself has stated, as major reforms are implemented, monitoring their effects should be given high priority, because these effects are uncertain and mid-course corrections may be required. The MAAC provisions are a prime candidate for such review and correction.

2. **The MAAC provisions apparently are beyond the administrative capabilities of Medicare carriers and HCFA.** ASIM can document hundreds of instances where carriers have provided incorrect MAACs; not provided MAACs at all; answered and interpreted policy questions incorrectly; and failed to comply with the mandates specified in the law, such as the requirement that the physicians be provided with their MAACs by March 1, 1987.

3. **There are serious problems and inaccuracies in the charge data maintained by Medicare carriers.** Those inaccuracies are so extensive that it raises questions not only about the validity of the MAAC program itself, but whether or not the Medicare program will be able to provide the type of accurate, historical charge data that may be needed by Congress and the Commission in considering future reforms in the payment system. Carriers, for example, frequently have been unable to recreate what physicians were charging for services prior to conversion to the HCFA Common Procedure Coding System; are unable to produce any accurate record of charges actually submitted by physicians in 1984; and have recorded charges for specific services that vary widely and unexplainably from actual physician charging patterns during April-June 1984, as documented by explanation of Medicare benefits (EOMB) forms and other records. ASIM will be providing Congress with hard documentation to support this conclusion within the next few days. Given that the ability to implement appropriate reform is dependent on the integrity of Medicare's data base, ASIM is extremely concerned about the widespread inaccuracies in Medicare's historical charge data.

4. **The MAAC limits are creating major and undesirable distortions in physician coding and billing practices.** Some physicians are being told, for example, that their maximum allowable actual charge limit for a "brief" office visit--defined in Current Procedural Terminology as a level of service requiring only an abbreviated history and examination--is higher than the maximum allowable actual charge for an extended office visit, defined as a service requiring an unusual amount of effort or judgment including a detailed history, review of medical records, and examination. It is difficult to believe that Congress intended for physicians to have higher fees for services that require minimal time and effort than for those that require more intensive skill, effort, and judgment. Yet, that is clearly the affect the MAAC limits are having on physician billing and coding practices.

5. **Some physicians are being forced to substantially reduce their charges for services, notwithstanding Congress' promise that the MAAC limits were intended as "relief" from the fee freeze. Moreover, there is no logical or rational policy basis for the services that are being singled out for reductions.** The question of whether or not a service is subject to reductions in charges is more a function of an arbitrary definition of when the services were rendered than any judgment about whether the service was overpriced. The result is that in many instances physicians who are charging relatively higher fees for their services are able to increase those fees by a minimum of 1 percent, while other

physicians providing the same service at lower fees are required to roll back their charges, simply because they did not provide the service during April-June 1984. From a logic and equity standpoint, this result makes absolutely no sense.

6. **The problems with the MAAC program are of such a magnitude that nothing short of complete repeal will resolve them in their entirety.** If Congress is not willing to consider repeal, certain modifications and mid-course corrections should be made to minimize some of the worse inequities and distortions resulting from the MAACs. Even with such mid-course corrections, however, the program in ASIM's view will remain fundamentally flawed.

The following describes in more detail the most serious problems, distortions and inequities created by the MAAC limits, and ASIM's recommendations for changes that may help improve the situation.

Services Provided by "New" Physicians

OBRA mandates that the MAACs for "new" physicians--those who did not provide services during April-June 1984--be based on the 50th percentile of customary charges for that service by established physicians during calendar year 1984. For many new physicians, this has resulted in a substantial reduction in their fees for some or all of their services.

New physicians are the only group that is categorically singled out for charge reductions under the MAAC provisions. The unfairness of this requirement is illustrated by the fact that even when a "new" physician is charging less for a given service than an established physician in his or her own community, the established physician is permitted to increase the charge by at least 1 percent while the "new" physician may be forced to reduce the charge. The following example illustrates how this can occur:

> Dr. Brown, an "established" physician who was in practice in April-June 1984, customarily charges $100 for an intermediate office visit. Since Medicare's prevailing charge in his area for that service is $50, his MAAC for 1987 is $101--a 1 percent increase over his current charge, notwithstanding the fact that his fee is already at twice the prevailing charge rate for his community.
>
> Dr. Green, a "new" physician who entered practice in July 1985, practices across the street from Dr. Brown. She has consistently charged $60 for an intermediate office visit since entering practice. Under the MAAC rules, however, since she did not submit any charges in April-June 1984, she is arbitrarily assigned a "customary" charge based on the 50th percentile of the fees submitted by established physicians in charge year 1984, or $45 in this example. Therefore, her MAAC is established at $48.12 (the 50th percentile plus one quarter of the difference between that and the prevailing charge multiplied by 1.15). Dr. Green does not understand why she is required to accept a reduction of almost $12 (or a 25 percent discount) from her current fee of $60, especially since her colleague Dr. Brown--who was charging twice Medicare's prevailing charge--is allowed to further increase that fee.

The above is not an uncommon example of the distortions and inequities created by the MAAC rules governing new physicians. There is no logical policy basis for forcing one physician to reduce his or her fees simply because a charge is not entered into Medicare's computers during April-June 1984, while another physician that charges the same or more for that service can increase that fee. Moreover, it is particularly ironic that Congress is requiring new physicians to reduce their charges since those physicians frequently have higher overhead costs and debt associated with starting a new practice--costs not incurred by established physicians. Many physician practices that have always charged uniformly for the services rendered by each physician in the group are now faced with the prospect of lowering the charges for their new associates, while maintaining or increasing the charges of established physicians in the group. Although ASIM believes that this problem--like others associated with the MAAC program--can only be truly corrected by repealing the provision altogether, Congress can begin to make it more equitable by amending the methodology mandated for calculating MAACs for new physicians. Specifically, Congress should:

> Allow any physician who has a 1987 customary charge profile (based on charges submitted July 1, 1985, through June 30, 1986) to use that profile in determining his or her MAACs. This would enable all physicians who entered practice and furnished

services from July 1, 1984, through June 30, 1986, to have their MAACs established on their own charging patterns, not on the 50th percentile of charges submitted during 1984. In the example cited earlier, Dr. Green--the "new" physician--would be permitted to use her $60 customary charge for an intermediate office visit, instead of the 50th percentile, with the result that her MAAC would by $60.60 in 1987--a far more fair and equitable limit. Similarly, physicians who entered practice and furnished services on or after July 1, 1986, through December 31, 1986, would have their customary charge for MAAC purposes based on their median charge for any services actually furnished during that six-month period of time. Those physicians with no charge history--i.e. those entering practice on or after January 1, 1987--could continue to have their charges established at the 50th percentile of 1984 customary charges, until such time as they have sufficient charges to establish their own customary charge profile. Congress could either mandate that all MAACs for new physicians be recalculated according to this methodology, or give new physicians the option of requesting a new MAAC based on their own customary charges.

On a related issue, some carriers are incorrectly classifying certain physicians as "new" physicians because they changed provider numbers (such as by joining a group practice) on or after July 1, 1984. As a result, the Medicare carriers' records show that those physicians submitted no charges during April-June 1984. Congress should require that the Health Care Financing Administration and its carriers base the MAACs for any individual physician on what their own charges were in April-June 1984, based on whatever provider number they were using at that time.

New Services

The methodology specified by OBRA for calculating MAACs for "new" services is essentially the same as for new physicians: services not furnished during April-June 1984 are established at the 50th percentile of charges for that service during charge year 1984. This has created two major distortions and inequities in Medicare's payment system:

- o Physicians are being forced to reduce charges for certain "new" services, even though those services were furnished prior to April-June 1984. This is especially a problem for certain seasonal, infrequent, or intermittent services provided by physicians. A service, for example, that was provided on March 30, 1984, would be considered under OBRA to be a "new" service, even though the physician has an established charge for that service and has not increased it since 1984. In ASIM's view, it is illogical to define an existing service as "new" simply because it was not furnished during an arbitrarily defined calendar quarter.

- o Physicians are being required to reduce their fees for new services provided on or after July 1, 1984, even though in many cases they have established a customary charge for the service. This leads to illogical distortions in physician charging patterns: a physician who learned a new service and began providing on or after July 1, 1984, will be required in many cases to rollback that fee, even though his or her fee may be established at or slightly above Medicare's prevailing charge; while another physician that provided the same service at a substantially higher fee during April-June 1984 (i.e. a fee considerably above Medicare's prevailing charge) will be permitted to increase that charge by at least 1 percent. This is particularly ironic since it is generally accepted that when a physician first begins providing a new service, his or her costs are generally higher, due to the initial cost of acquiring equipment, learning the skills to provide the service, hiring additional staff, etc. In general, however, those costs decrease over time as a physician becomes more proficient in the procedure and as the physician no longer incurs the initial acquisition costs.

ASIM strongly believes that to begin remedying this situation, Congress should repeal the MAAC provisions in OBRA or amend the OBRA provisions to:

1. Allow any physician that can document that he or she furnished a service to a Medicare beneficiary during the 12 months ending June 30, 1984, to apply with the carrier to have that charge or charges used to calculate his customary charge as a basis for determining the MAAC. This would help resolve the problem of services that physicians provided and billed for prior to April-June 1984 (and have continued to do so), but that were simply not furnished during

the arbitrary April-June 1984 base period. It would not, however, correct the problem of new services provided on or after July 1,1984. Therefore, the second option--described below--is preferable, since it would help solve both of the inequities and distortions described earlier with the MAACs as they apply to "new" services.

2. For services rendered on or after July 1, 1984, establish the MAAC based upon the physician's own customary charge for that service. For new services provided from July 1, 1985, through June 30, 1986, Medicare already has an established customary charge profile for that service which can be used to calculate the MAAC. For new services provided from July 1, 1986, through December 31, 1986, it is possible for the Medicare carrier to calculate a customary charge for the service based upon charges submitted during that six-month period. Only those new services rendered on or after January 1, 1987, would be assigned at the 50th percentile level until such time as a physician has an established customary charge for the service.

Coding Problems

It is apparent that as a result of major problems in Medicare carrier conversion to the HCFA Common Procedure Coding System (HCPCS), physicians are improperly and incorrectly being assigned MAACs that have no relation to their actual charging patterns for April-June 1984. Although ASIM is unable to determine precisely why such problems are occurring, there is considerable evidence that major problems are occurring as a result of the conversion. As noted earlier, carriers, for example, are calculating higher MAACs for lower levels of service (such as "brief" services) and lower MAACs for higher levels of care (such as intermediate or extended visits). Other physicians who had a clearly established charge for a service during April-June 1984 are being assigned MAACs based on the 50th percentile level, simply because Medicare now uses a different code for that service. Still others are finding that Medicare has absolutely no record of charges that the physician can document were furnished during April-June 1984 or, conversely, have assigned physicians with MAACs for services that they never provided (several internists, for example, have been assigned MAACs for optometrist's services). HCFA's instructions to carriers on how to deal with the conversion problems in calculating MAACs are unclear and ambiguous, with carriers being given wide discretion to calculate a new base MAAC "by merging, splitting, or otherwise adjusting codes from the 1984 quarter or the 50th percentile charge year, as appropriate."

In addition, despite the legislative mandate for carriers to provide MAACs for the "most frequent" procedures provided by individual physicians no later than March 1 of each year, ASIM can document many cases where carriers have still not provided those MAACs to physicians. This is particularly disturbing given the fact that HCFA--in an agreement with the American Medical Association over a law suit challenging the new program--agreed that all carriers will provide the MAACs no later than January 31, 1987. Moreover, several carriers--by their own admission--calculated the initial set of MAACs incorrectly. Blue Cross and Blue Shield of Maryland, for example, has agreed to recalculate all of the MAACs provided to physicians, while at the same time acknowledging that there may be "additional errors" in the new MAACs.

ASIM strongly urges Congress to:

1. Investigate how HCFA and its carriers are handling coding conversions in determining MAACs for 1987, and make it explicit that Congress intends that coding conversions should be handled in such a way that physicians who have an established charge for a service should be able to maintain that charge, notwithstanding the fact that a new code may have been assigned for the service. Moreover, HCFA should be instructed to handle carrier conversions in such a way as to preserve the integrity of the HCFA Common Procedure Coding System, by assuring that the MAACs assigned for each level of care correspond to the amount of time and effort involved in providing each visit category.

2. Enjoin HCFA from using any charges submitted during the first quarter of 1987 in determining physician compliance or noncompliance with the MAAC program. Given the fact that MAACs were not available for all or much of the January-March 1987 period, and that many of those MAACs were calculated incorrectly, physicians should not be liable for having charges submitted during that period of time included in HCFA's monitoring to determine compliance with the MAACS.

Other Problems

Although the above situations are among the most egregious problems resulting from the MAAC program, ASIM will be providing Congress and this Subcommittee with additional documentation and recommendations on problems, inequities, and distortions created by the MAAC program. ASIM emphasizes that although some corrective technical amendments may help alleviate some of the worse problems with the MAACs, nothing short of complete repeal will successfully and effectively resolve problems of this magnitude. ASIM looks forward to working with the Subcommittee in developing solutions to the problems experienced with the MAACs. Moreover, ASIM strongly urges Congress to conduct oversight hearings on how HCFA and its carriers have complied with the mandates in the OBRA statutes and on how those provisions are affecting the physician payment system under Medicare.

MD-DRGs

ASIM strongly opposes the Reagan Administration proposal to begin paying for physician services on the basis of Medicare's prospective pricing system (PPS) based on MD-DRGs. ASIM believes it significant that over 200 members of the House of Representatives apparently agree that this proposal is not advisable, as indicated by their cosponsorship of H. Con. Res. 30, which expresses strong opposition to MD-DRGs or mandatory assignment at least until such time as a resource cost relative value scale is developed.

ASIM strongly believes that a MD-DRG system for paying for physician services to hospitalized Medicare patients remains a largely untested system that could potentially a) undermine the quality of care provided to Medicare patients, b) create undesirable conflicts in the hospital medical staff, particularly if the medical staff is identified as the unit of payment for receiving and dispersing funds, and c) create conflicts between the hospital administration and physicians who furnish services in that hospital. Under the current system of payment, physicians can resist pressure from hospitals or PROs to discharge patients prematurely or fail to provide needed services to their hospitalized Medicare patients. Several surveys by the AMA, ASIM, the Senate Aging Committee, and others have demonstrated that under the existing hospital PPS program, some patients are being discharged prematurely. If physicians are placed in the same financial incentives as the hospital, this trend is likely to be exacerbated. It is significant that DHHS' own draft report to Congress (never released) concluded that MD-DRGs are not a desirable reform at this time, stating that "given trends observable at this moment, it is not clear how much PPS for physicians can control Medicare outlays, and there is ground for concern that burdens can be transferred to beneficiaries; effects on access of care are uncertain, and administrative feasibility is unproven. Finally, although PPS for physicians appears to support movement towards capitation because it involved bundling, PPS for physicians rests on fixed payment rates which will not support competition or consumer choice."

Although ASIM recognizes that the Administration "compromised" by limiting its proposal to paying for services by radiologists, anesthesiologists, and pathologists (RAPs) only under DRGs, ASIM believes that the Administration's ultimate intent is to include all physician services under MD-DRGs. Once this concept is accepted for one segment of the medical profession, it is easy to justify expansion of it to other physician services. Moreover, even if limited to RAPs, MD-DRGs are likely to have several undesirable effects on quality and availability of care provided to Medicare patients:

1. They may encourage hospitals to decide, on the basis of price only, whom they wish to contract with to provide RAP services. This could particularly be a problem if payment for RAPs comes out of the same pot of money that goes to the hospital. To the extent the lowest cost radiology, pathology, and anesthesiology groups are not necessarily the "best," this would be detrimental to the quality of care provided to hospitalized Medicare patients.

2. The hospital would have an incentive to decide when pathology and radiology services will be involved, and potentially to limit internists' access to needed pathology and radiology services.

3. MD-DRGs for RAPs could create an incentive for hospitals to reduce the number of anesthesiologists on the staff by replacing them with nurse-anesthesists that could administer anesthesia under the supervision of a fewer number of anesthesiologists. Instead of one anesthesiologist being available for each surgical procedure, there might instead by one anesthesiologist supervising several nurse-anesthesists administering anesthesia during several concurrent operations. This would undermine quality of care and place more liability on the hospital, surgeon, and internists involved in treating each patient.

Finally, ASIM strongly believes that given the widespread support for a resource cost relative value scale (RVS) as a basis of determining a schedule of allowances under Medicare, Congress should not now embark on an untried and untested alternative payment methodology. Once a resource cost RVS is available, Congress will for the first time have a logical, rational basis for determining levels of payment under the Medicare program in a way that is far more predictable and understandable for beneficiaries and physicians, without the potential adverse impact on quality and availability of care associated with MD-DRGs.

Conclusion

In conclusion, ASIM strongly urges Congress to carefully review the recommendations of the Physician Payment Review Commission and take appropriate action to facilitate those recommendations. The Society strongly believes that the Commission's first report to Congress provides a good basis for moving forward on payment reform. The Society particularly urges Congress to adhere to the goals stated by the Commission in enacting further changes in Medicare's system of payment for physician services.

The Society also urges Congress to review the problems experienced by physicians with the MAAC limits, and take appropriate action to correct those problems, inequities, and distortions. ASIM strongly urges Congress to consider repealing those provisions altogether. At a minimum, Congress should enact corrective legislation to alleviate the most serious problems with the MAAC provisions, including their effect on new physicians and new services. ASIM will be sharing with this Subcommittee additional documentation and recommendations in the very near future.

Finally, ASIM strongly urges Congress to reaffirm its support for moving Medicare towards a schedule of allowances based on resource costs, as supported by the Physician Payment Review Commission. While such an RVS is being developed, Congress should refrain from enacting major changes in the Medicare physician payment system, such as the Administration's proposal to begin paying for physician services under the basis of DRGs.

ASIM welcomes the opportunity to work with this Subcommittee in the future in developing rational solutions to the problems facing the physician payment system under Medicare.

G-BD-0712

STATEMENT OF MARTIN A. COHN, M.D., MOUNT SINAI MEDICAL CENTER, SLEEP DISORDERS CENTER, MIAMI BEACH, FLORIDA, ON BEHALF OF THE ASSOCIATION OF PROFESSIONAL SLEEP SOCIETIES

Mr. Chairman and Members of the Subcommittee, the Association of Professional Sleep Societies is pleased to present our views concerning physician payment under the Medicare Program. As you well-know, our population's age distribution is shifting towards the elderly. Each year, a greater proportion of our medical practices are comprised of Medicare patients. The elderly have more diseases as a group and are individually more likely to have multiple diseases. New technologies can diagnose and treat those elderly at risk for medical catastrophes before death or disability claim their tolls in quality of life and Medicare expenditures. The control of high blood pressure is just one example.

My specific message to you today is that many of these diseases, particularly those of the heart and lungs, change for the worse on a nightly basis during sleep. In people over 65 years of age, most disease-related deaths and disease-related medical catastrophes (such as heart attack and stroke) occur during the hours of sleep. Any new reimbursement proposals for physicians, such as prospective plans based on Diagnostic Related Groups, must recognize the 24-hour nature of disease and accordingly provide for responsible care. It is medically wrong, for example, to treat, with antihypertensive drugs and stimulants, an elderly man with hypertension who falls asleep at the wheel of his car and snores every night. Such a treatment may lead to stroke, heart attack or a multi-vehicle accident. Yet, current Medicare guidelines and payment policies force the health care system into such short-sighted treatments because patients cannot afford the necessary tests for sleep related abnormalities. A further ratcheting down of these policies in the name of cost containment would present additional likeliness of catastrophe.

Most sleep disorders centers are run by specialists in internal medicine who have studied for additional accreditation in diagnosing and treating sleep disorders. The emphasis on internal medicine and specialized training stems from the fact that most frequent sleep disorders are associated with life-threatening cardio-pulmonary problems during the night, such as sleep apnea, asthma, heart disease and chronic obstructive pulmonary disease.

Our ability to differentially diagnose patients with sleep complaints has progressed rapidly in the past ten years. We now have well-accepted guidelines and rationales for treating sleep disorders with surgery, mechanical devices, medication or some combination of these approaches. There is broad consensus as to the life-threatening nature of cardio-pulmonary abnormalities in sleep and risks of falling asleep while driving a vehicle or operating dangerous machinery. Furthermore, recent studies indicate that over 90% of the patients evaluated by sleep disorders centers are significantly improved by recommended treatments. The great impediment that we face as clinicians is that the elderly are reluctant to seek out our expertise because Medicare already pays so little for the costs associated with testing. This fact has recently been supported by reports from members of the Association of Professional Sleep Societies. I will describe two types of life-threatening, yet treatable, medical conditions. For both, current Medicare policy effectively prevents treatment due to inadequate reimbursement.

Inappropriate use and overuse of sleeping pills is particularly common in elderly, Medicare patients. Many patients began such treatments years before modern knowledge was available. Most of the prescriptions for sleeping pills are written for this category of patients. Research indicates that cardio-pulmonary disorders, also common in the elderly, are exacerbated by sleep and account for the disproportionate number of medical catastrophes that occur during the night. Sleeping pills enhance the depression of respiration and cardiac function that normally accompanies sleep. Inappropriate use of sleeping pills in the elderly may also contribute to confusion and locomotor problems and thus potentiate accidents and falls. This vicious cycle can now be broken with rational approaches to problems of sleep in the elderly.

Second is the major problem surrounding people who cannot stay awake to function. Such patients often take prescribed stimulants, to help them stay awake while driving a vehicle or during activities that require sustained alertness. The United States Senate, in report #99-152 accompanying the fiscal year 1986 Appropriations Bill for the Department of Transportation, has recognized the potential impact these disorders have on highway safety. Stimulants, such as amphetamines, are proper treatment for only 10% of the people who have prescriptions for stimulants. For example, the most common cause of an inability to stay awake in the day is the disorder of sleep apnea which is characterized by symptoms of loud irregular snoring and high blood pressure. Stimulants are medically inappropriate for such patients. Now we know how to correctly diagnose conditions of excessive somnolence and provide appropriate treatment for the millions of Americans with these symptoms.

We ask that this Subcommittee carefully review reimbursement practices for Medicare patients and suggest that revisions to the Medicare Guidelines be made which are in line with present knowledge and standards of practice. As a further policy recommendation, we do not believe it is advisable to increase Part B preminums or raise deductibles. Right now, access and affordability are major obstacles to many elderly persons seeking health care. To put this basic need out of reach to more elderly persons, does not make good fiscal sense.

Thank you for the opportunity to present our views.

STATEMENT OF THE NATIONAL ASSOCIATION OF MEDICAL DIRECTORS OF RESPIRATORY CARE

The National Association of Medical Directors of Respiratory Care (NAMDRC) is a professional organization composed of physicians who serve as medical directors of respiratory care programs in over 2000 hospitals nationwide. Eighty five per cent of our membership is composed of pulmonologists and internists, and 12% are anesthesiologists.

NAMDRC recognizes the need for reform on physician payment. While we have no specific solution to this problem, we are able to offer guidelines which the Committee ought to consider as it develops alternative reimbursement plans. Any alternative to the existing system must insure access to care, high quality of care, and reasonable cost.

The Physician Payment Review Commission, has not specifically addressed the issue of hospital based physicians. It has recommended the establishment of a nationwide fee schedule with minimal adjustments to account for differences across geographic lines. This does not really solve the problem we are faced with in the physician community.

We understand that one popular solution under consideration is the concept of "mandatory assignment" where a physician must accept Medicare payment as payment in full for services performed in a hospital for a Medicare beneficiary. We acknowledge that this solution may be attractive politically to the Congress, but we must question whether it will encourage physicians to accept Medicare patients in the first place. Obviously, it also inhibits and probably strikes dead the concept of freedom of choice, a critical pillar of the Medicare program.

Another proposal being debated is the so-called RAP approach, which would single out certain physician groups within the hospital and eliminate their ability to bill for hospital-based services. The billable amounts incurred would be added to the hospital's DRG payment, and the physician would then recover from the hospital appropriate payment.

Aside from the mechanics and politics of such an approach, we think it is unfair and, in reality, shifts payment problems rather than solving them. It forces hospitals to develop new paperwork systems to accomodate such physician payments. Additionally, we would assume the hospital would not be reimbursed by Medicare for such costs. More than likely, the hospital would deduct administrative costs from the payment, lessening the amount legitimately due the physician.

The predicament, quite clearly, is to build a new system of equitable payment for physician services. This sytem must be administratively acceptable, not adversely affect a patient's ability to secure appropriate care, and have fiscal constraints. Any new system should reimburse physicians for effective services but should not perpetuate incentives for inappropriate or ineffective care. A new system should be based on objective, quantifiable data and not on historical or normative charges, opinions or anecdotes. The new system should not be rigid and must foster effective innovations in patient care and technology and also must accomodate valid changes in medical practice. Any new system must acknowledge the best interests of the patient and allow for access to quality care.

There are several systems of physician payment undergoing research at this time. We urge the Committee to defer any decisions on physician reimbursement until the results from the research on physician payment are available.

THE SOCIETY OF THORACIC SURGEONS

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March 19, 1987

The Honorable Fortney H. Stark
Subcommittee on Health
House Ways & Means Committee
1114 Longworth House Office Building
Washington, DC 20515

Dear Mr. Stark:

We understand that several references were made during the hearings on physician reimbursement March 3 to current levels of reimbursement for coronary artery by-pass surgery, pacemaker implantation, and coronary balloon angioplasty.

As you recall, the Sixth Omnibus Budget Reconciliation Act last year directed the Health Care Financing Administration to review a number of surgical procedures to determine if changes in reimbursements should be made on the basis of specific criteria set forth by the Congress. At that time, HCFA already had underway examinations of the average allowable charges and trends in the resources required for coronary artery by-pass surgery and pacemaker implantation. We have met several times with the staff of the Health Care Financing Administration to make suggestions concerning the methodology being used for these studies and look forward to reviewing any conclusions, when released.

In addition, the Harvard Resource Based Relative Value Study includes a review of the charges and resource-based inputs for thoracic surgical procedures; three members of the Society of Thoracic Surgeons and the American Association for Thoracic Surgery (including the under-signed) serve on the technical advisory panel for this study. We would note that the average patient age and the degree of complexity of coronary artery by-pass surgery has increased significantly since the preliminary data from Massachusetts in 1983 given in an appendage to Dr. Hsiao's statement. If these changes and the difficulties of these procedures are properly factored, we expect that the Harvard study now in progress will show results quite different from this preliminary 1983 report.

The Society continues ready to assist HCFA, the Harvard study group, and the Congress in the development of new proposals for reimbursement for surgical procedures.

Sincerely,

THE SOCIETY OF THORACIC SURGEONS

John E. Albers

John E. Albers, M.D.
Chairman
Government Relations Committee

JEA/st

Submitted by
Charles E. McConnel, Ph.D.
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Justifying Mandatory Assignment of Physician Reimbursement Under the Medicare DRG Payment System

Among the many proposed changes in the Medicare system contained in the Reagan Administration's most recent Budget, none perhaps is as controversial as the inclusion of reimbursement of services performed by radiologists, anesthesiologists, and pathologists (RAP) under the prospective payments system; a system of payment currently limited to reimbursement of hospital care for Medicare patients. As a result, this proposed change in reimbursement of physician services and what such a change might portend for the future of fee-for-service practice by other physician groups, has been met with acrimony by the medical profession. Although the plan does not mandate that Medicare reimbursement of physician services be accepted as payment in full- a crucial difference between this proposal and provisions governing Medicare's DRG reimbursement for hospital services - the AMA will nonetheless, "use every possible means to defeat this proposal" (McGraw-Hill, 1986).

In the following sections we briefly examine the trend in earnings of RAP's relative to other physicians between 1973 and 1984, the relative economic status of RAP's over the period, and the financial rate of return in 1984 associated with an investment in training in each of the RAP specialties. We conclude by noting the enormous relative pecuniary advantages that accrue to these three clinical service specialties and the difficulty in justifying this disparity under generally accepted principles of human capital theory.

Earnings Trends and Relative Earnings

Table 1 and 2 present data from the AMA's Socioeconomic Characteristics of Physicians on pre-tax mean earnings net of expenses for all physicians, primary care physicians, general and family practitioners, radiologists, anesthesiologists and pathologists for 1973 and 1984. While earnings for primary care physicians, a category comprised of general and family practitioners, internists and pediatricians is not reported in the SMS, for purposes of this analysis, primary care earnings was computed as a weighted average based on reported earnings for the respective specialties and the proportionate representation of each of the three primary physician specialties as reported in the AMA's Physician Characteristics and Distribution in the U.S.. Earning trends for pathologists could not be examined because of the lack of 1973 data in the SMS reporting system.

With respect to earnings trends, percentage increases between 1973 and 1984 in annual earnings (Table 1) of 136% for radiologists and 202% for anesthesiologists exceeded the all physician average of 123% and were much larger than the increases of 95% for primary care physicians and 70% for general and family practitioners. Earnings differentials (excluding pathologists in 1973) for the RAP's were all greater than one when compared to all physicians, primary care physicians and general practitioners in both 1973 and 1984, with the exception of anesthesiologist's earnings when compared to all physician earnings in 1973. By 1984, the RAP's (including pathologists) relative earnings advantage had widened considerably, with the

Table 1. Comparison of Annual Earnings, Trends and Relative Earnings for Radiologists, Anesthesiologists, Pathologists, All Physicians, Primary Care Physicians and General and Family Practitioners: 1973-1984*

	1973				1984				1973-1984
Specialty	Pre-tax Mean Net Earnings	Ratio of Specialty to All Physician Earnings	Ratio of Specialty to Primary Care Earnings	Ratio of Specialty to GP/FP Earnings	Pre-tax Mean Net Earnings	Ratio of Specialty to All Physician Earnings	Ratio of Specialty to Primary Care Earnings	Ratio of Specialty to GP/FP Earnings	Percent Change in Earnings
Radiologists	$59,500	1.22	1.35	1.42	$139,800	1.29	1.63	1.97	136%
Anesthesiologists	48,100	.99	1.09	1.15	145,400	1.34	1.69	2.05	202%
Pathologists	-	-	-	-	118,000	1.09	1.37	1.66	-
All Physicians	48,600				108,400				123%
Primary Care Physicians**	44,060				85,926				95%
General and Family Practitioners GP/FP	41,900				71,100				70%

*Data for 1973 and 1984 are not strictly comparable due to underreporting of deferred income in 1973. However the effect of the distortion between group comparisons are assumed to be of little significance.

**Weighted averages based on proportionate representation of general and family practitioners, internists and pediatricians in the primary care group.

Source: American Medical Association, Socioeconomic Characteristics of Medical Practice, 1984; 1985.

most salient comparison, that with primary care specialists, indicating that radiologist and anesthesiologists earning were approximately twice as large while pathologist earnings were nearly 70% larger than the average for primary care specialist. When converted to hourly earnings (Table 2), the 1984 discrepancies are slightly reduced. Nonetheless, under the hourly earnings measure, each of the RAP's earnings exceeded that of the primary care specialists by over 70% and exceeded the all physician average hourly earnings by over 30%.

Internal Rates of Return

An alternative way of viewing the relative economic status of radiologists, anethesiologists and pathologists is to examine the financial returns expected to accrue to the investment in human capital entailed in specialty training. Rates of return in this case are a convenient quantification of the individual's expectation that the cost of investment, in the form of foregone income and other costs incurred during the training period, will be more than offset by a enhancement of lifetime earnings. The computational procedure, formalized in Appendix I, computes the internal rate of return as the rate of discount (or interest) that equates the cost of specialty training with the present value of expected additions to lifetime earnings. When the rate of return compares favorably to the return on alternative investment opportunities or career choices, the investment is considered profitable. Rates of return thus require a

Table 2. Comparison of Hourly Earnings, Trends and Relative Earnings for Radiologists, Anesthesiologists, Pathologists, All Physicians, Primary Care Physicians and General and Family Practitioners: 1973-1984*

	1973				1984				1973-1984
Specialty	Pre-tax Mean Net Earnings	Ratio of Specialty to All Physician Earnings	Ratio of Specialty to Primary Care Earnings	Ratio of Specialty to GP/FP Earnings	Pre-tax Mean Net Earnings	Ratio of Specialty to All Physician Earnings	Ratio of Specialty to Primary Care Earnings	Ratio of Specialty to GP/FP Earnings	Percent Change in Earnings
Radiologists	30.22	1.35	1.53	1.63	61.10	1.35	1.78	2.18	102%
Anesthesiologists	21.37	.96	1.08	1.15	58.75	1.30	1.71	2.10	175%
Pathologists	-	-	-	-	59.03	1.31	1.72	2.10	-
All Physicians	22.34				45.22				102%
Primary Care Physicians**	19.78				34.41				74%
General and Family Practitioners GP/FP	18.57				28.04				51%

*Data for 1973 and 1984 are not strictly comparable due to underreporting of deferred income in 1973. However the effect of the distortion between group comparisons are assumed to be of little significance.

**Weighted averages based on proportionate representation of general and family pracititioners, internists and prediatricians in the primary care group.

Source: American Medical Association, Socioeconomic Characteristics of Medical Practice, 1984; 1985.

comparison of lifetime earnings between groups with differing amounts of training and expenses incurred in education and training.

In this analysis we examine the rates of return accruing to specialty training in radiology, anesthesiology and pathology relative to training investments required by the general and family practitioner which measures the return to training beyond medical school and licensure, and then relative to the average primary care physician, whose training is less extensive than the three specialties of interest. Rates of return to the three specialties are then compared to the rate of return for the average physician, first using general and family practitioners as a reference group, then primary care specialists as a reference group. Finally, a comparison is made between the three specialties and primary care physicians using general and family practitioners as the reference group.

To ascertain the number of years of residency normally expected for each of the categories of physicians, the respective certifying specialty boards were consulted. The duration of residency for the average physician was taken from estimates made by Schroeder (1984). The duration of residency for each group used in this analysis is as follows:

Average Physician	4 years
Radiologists	4 years
Anesthesiologists	4 years
Pathologists	4.25 years
General and Family Practitioners	1.69 years (weighted average)
Primary Care Specialists	3.07 years (weighted average)

With reference to Table 3, it is readily apparent that the internal rates of return to specialty training in radiology, anesthesiology and pathology are exceptionally high when compared to alternative training or specialty options. Without an adjustment for differences in hours worked and using general and family practitioners as a reference group, the rate of return to specialization in radiology is 60% higher than the return to training by the average physician (.293-.183/.183), 70% higher for anesthesiologists and 20% higher for pathologists. When adjusted for the shorter hours worked by radiologists, and pathologists, radiologists have a 63% advantage and pathologists a 56% advantage over the average physician.

When compared to the primary care physician, whose length of residency is on average approximately a year less than the three specialties, the advantage is even more dramatic. For instance, radiologists can expect a rate of return to training 112% (.293- .138/.138) greater than the average primary care physician while anesthesiologists and pathologists can expect relative advantages of 125% and 59% respectively.

A less relevant, but interesting comparison is also possible when the rate of return is computed using investment in the primary care specialties as the reference point.* Without adjusting for annual hours worked, the average physician's (which includes all specialties) rate of return is .234 compared

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*The underlying logic of this comparison rests on change of speciality research showing large net losses for family practice and internal medicine and large net gains for radiology, anesthesiology and pathology (Tardiff, et al, 1986).

Table 3. Comparison of Financial Rates of Return* to Specialty Training for All Physicians, Radiologists, Anesthesiologists and Pathologists

	Relative to Medical Education and Licensure**		Relative to Primary Care Specialties***	
Specialty	Actual (unadjusted)	Adjusted (for differences in annual hours worked)	Actual (unadjusted)	Adjusted (for differences in annual hours worked)
All Physicians	.183	.207	.234	.275
Primary Care Physicians	.138	.150	-	-
Radiologists	.293	.337	.563	.651
Anesthesiologists	.310	.320	.529	.538
Pathologists	.219	.322	.268	.456

*The discount rate that equates the present value of lifetime earnings for speciality and reference groups.

**Using income and weighted average of number of years in residency for General and Family Practitioners.

***Using weighted averages for General and Family Practitioners, Internists and Pediatricians.

Source: American Medical Association, Socioeconomic Characteristics of Medical Practice, 1985 and Physician Characteristics and Distribution in the U.S., 1984.

to the radiologist's which equals .563, a difference of 140%, anesthesiologists, .529 (123% larger) and pathologists, .268 (15% larger). When adjusted for annual hours worked, the radiologist's advantage falls, yet is still 96% greater than the return to primary care and the pathologist's advantage rises to 66%, the difference being due to differentials in annual hours worked relative to the primary group.

Discussion

Individual decisions regarding the pursuit of a medical career can be characterized by a recursive decision structure whereby the decision to enter medical school is the first stage and the decision to either enter practice following graduation and one year of residency for licensure or to continue in a residency program leading to one or another specialty the second stage. To ascertain the relative economic rewards accruing to the pursuit of a given specialty, comparisons with the alternatives foregone, that of entering practice must be made as well as comparisons with the rewards accruing to alternative specialties, i.e., alternative career choices. While a variety of comparisons is possible, this analysis was primarily concerned with a comparison of the rate of return accruing to the additional training investments of the average physician and the average primary care physician with the rates of return accruing to radiologists, anesthesiologists and pathologists. Our computations indicate that in 1984, there was a substantial premium associated with training in the three clinical service specialties. While it is beyond the scope of this analysis to attempt to isolate the sources of this differential, it is difficult to believe that the enormous earnings advantage enjoyed by the three clinical service specialty groups can be attributed to factors typically invoked to explain differences in lifetime earnings within the human capital framework. It is of course possible, but unlikely that the observed advantages represent risk premiums for relatively higher expected failure rates in the three clinical service residency programs. However, the pecuniary cost of default in this case is limited to the difference between the earnings of a general practitioner and the (substantial) stipend of the resident over the duration of the interrupted training program.

A more plausible explanation is that the complement of individual characteristics required for successful completion of the respective residency programs and certification is so unique as to render the supply of qualified applicants highly inelastic. In such a case, disproportionately high returns in these specialties would not induce an appropriate increase in the number of qualified applicants, assuming the corresponding number of residency positions were available. Although the available evidence bearing on this hypothesis is indirect, it does suggest the absence of any peculiarities in the past growth and current resident/position matching process. Moore and Lang (1981) indicate that the percentage increase in board certification between 1966 and 1976 for radiology, anesthesiology and pathology was 83% compared to 43% for the surgical specialties and 203% for the medical specialties. In addition, the NRMP Director (1984) indicates that for 1985, applicants per position in the three specialties was approximately equal to the mean of 8.8 and that the percent of positions filled was close to the average for the 28 specialties listed (Table G). Moreover, the GMENAC projects a substantial surplus in radiology and pathology by 1990.

A more reasonable explanation for the persistence of disproportionately high rates of return to radiology, anesthesiology and pathology centers on expected economic outcomes associated with patient intake, practice setting and the attendant scheme of reimbursement. Since these clinical service specialists rely almost exclusively on referrals from other physicians and for the most part perform their services in a hospital setting, it is reasonable to assume that their professional activities and the income they generate are substantially more insulated from the competitive pressures of the marketplace than are the services of other categories of physicians. It is this lack of even a modicum of market discipline over fee structures and earnings that suggests a rationale for regulatory intervention, including prospective reimbursement with mandatory assignment (cf. Culler and Ehrenfried, 1986).

Appendix

Following Rosen (1977), Sloan and Feldman (1978) and Burstein and Cromwell (1985), computation of the internal rate of return assumes a rectangular earnings distribution Y over an infinite future, i.e., retirement is neglected. Let the reference groups earnings be Y_R beginning in year S_R and a given specialists earnings per year be Y_s beginning a some later time (i.e., duration of training) S_s. The present value of each of the two earnings streams at discount rate r_i is,

$$V_R = \int_{S_r}^{\infty} Y_R e^{-r_i t} dt,$$

$$V_S = \int_{S_s}^{\infty} Y_s e^{-r_i t} dt.$$

Integrating these expressions gives,

$$V_R = \frac{Y_R}{r_R} e^{-r_i S_R}, \qquad V_S = \frac{Y_s}{r_s} e^{-r_i S_s}$$

and the internal rate of return, r, is that discount rate that equates V_R and V_S :

$$\frac{Y_R}{r} e^{-rS_R} = \frac{Y_S}{r} e^{-rS_s}$$

or

$$Y_s = Y_R e^{r(S_s - S_R)}$$

Rearranging terms and taking logs gives,

$$\frac{Y_S}{Y_R} = e^{r(S_S-S_R)}$$

or

$$\frac{\ln\left(\frac{Y_S}{Y_r}\right)}{S_S-S_R} = r$$

Since earnings Y is equal to hours worked N times hourly earnings W, the formula can be decomposed to further adjust for differences in annual hours worked as follows:

$$\frac{\left[\ln\left(\frac{W_S}{W_R}\right) + \ln\left(\frac{N_S}{N_R}\right)\right]}{S_S-S_R} = r$$

and the rate of return adjusted for hours worked is,

$$\frac{\ln\left(\frac{W_S}{W_R}\right)}{S_S-S_R} = r_a$$

While several adjustments of the lifetime earnings values and trainings cost have been suggested by Burstein and Cromwell (1985), none would materially affect the comparisons entertained in this study. For this reason, adjustments for retirement and differences in residency salary offsets to training costs for residencies of differing duration have not been made.

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